VOLUME 2

A COLLECTION OF FOUR PROFESSIONAL PRACTICE REPORTS

by

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Chapter 4. Professional Practice Report 3

CHAPTER 1- INTRODUCTION

1.1 Introduction

This overview outlines the local context in which I completed four Professional Practice Reports (PPRs) as part of the requirements from the University of Birmingham in order to complete the Applied Educational and Child Psychology Doctoral Programme from 2008 to 2011. Section 1.2 details information about the authority in which I worked including an overview of the population and level of need within the area. Section 1.2.1 details information about the service's model of delivery in light of a changing context. Section 3 provides an overview and rationale for the PPRs and then goes on to introduce each of the four PPRs within the context of the service in which I work and my own professional development. Section 4 provides a brief reflection of my professional development in light of completing the PPRs.

1.2 Contextual information

For the last two years, I have been employed as a Trainee EP (TEP) in a local Educational Psychology Service (EPS) within the West Midlands. The authority in which I work is England's largest urban authority, with a population of about one million people (Ofsted, 2007). The authority reflects a diverse population within the West Midlands. In the Joint Area review of the Las Children's Services, Ofsted (2007) describe parts of the city and it's constituent communities as having;

'High levels of multiple deprivation with associated problems of crime, poor health and unemployment' (p.5).

Overall unemployment rates (5.1%) within the authority are significantly higher than the national average (2%) (Office for National Statistics, 2001). Significantly more affluent areas are also represented within the city and tend to be located in the North area. Educational Psychologists (EPs) working within the authority are distributed between six area teams. I was employed to work in the North area of the city, some areas of the North represent a particularly affluent population within the city although within this area there are pockets are significant economic deprivation. I work in two area of the North which represent a high level of economic and cultural deprivation and unemployment.

The local population is amongst one of the most diverse in the country, almost 30% of the total population is from minority ethnic communities, the largest communities being South Asian although the city has recently welcomed new arrivals from Africa and Eastern Europe. Around half of pupils in Birmingham schools identified themselves as being from minority ethnic communities (Office for National Statistics, 2001). All schools in total cater for 177, 981 children and young people of whom 4000 are registered disabled. There are 2,060 children who are looked after by the council and 1,127 children on the child protection register. Approximately 30% of children live in one parent households which is far higher than the national average which is 6.5% (Ofsted, 2007).

1.2.1 Service delivery

My time as a TEP in a West Midlands authority has reflected a time of change at a national level due to our new collation government. Financial cuts across children's services has created feelings of anxiety and uncertainty across the workforce and has also changed the LA's model of service delivery. Previously, area teams have not been co-located as multi-agency teams, a practice which many other authorities have adopted. Instead, each service functions independently although multi- agency working is encouraged at every level and EP's within the authority strive to work alongside other professionals on individual case work, within schools and in the community when working on various projects. New service structures are currently being discussed, however it is likely that four new area teams will represent the whole of the authority and each team will consist of a range of professionals including representatives from education, health, social care and the police.

Schools have previously received a service that is not based on a time allocation model but rather based on a 'needs led' model whereby the school's visiting EP is able to use their own professional judgment and time management to determine how many hours they provide to their schools. This enables schools to prioritise areas of work for the EP and also enables the EP to engage in more project and research based work within some of their schools. However, in light of recent changes within the government the service has moved towards a traded service model of delivery whereby schools have been asked to buy back services from the EPS. Schools would therefore be buying back into an allocated number of hours per year with additional options for training and continued professional development. Statutory work will be delivered to schools as part of a separate 'core' allocation. All schools that buy the EPS

back will therefore be allocated the same number of hours which may represent a more equitable system. This traded model of service delivery is currently in its early stages and so it is difficult to foresee what this work might look like. This may be an opportunity for EPs within the service to engage in more therapeutic interventions with individuals and small groups or perhaps to deliver training in areas determined by the needs of school.

This time reflects one of fast paced change and challenge but also could present EPs with opportunities and more innovative and creative ways of working. One way forward may be to conduct a needs analysis with all schools in the authority with a view to match the services that we can offer with the needs and direction of schools, educational settings and the community.

1.3 Overview and rationale for the professional practice reports

It is within this context that I completed four PPRs. PPRs comprise exemplar reports of selected areas of the supervised professional practice undertaken during the second and third years of the postgraduate professional training programme. Empirical work toward these practitioner reports is governed by professional codes of ethics and standards for EPs set out by the British Psychological Society and Health Professions Council to which we subscribe in our studies, and which the University endorses with rigour, within its own Fitness to Practice Code and Regulations. The University provided guidance about the broad areas on which the PPRs should focus. Part of our role within the context of our LA was to negotiate opportunities to complete assignments based on the requirements from university as well as the needs and priorities of the service.

Within these broad areas set out by the university, PPR 1 covers an account of assessment and intervention with a group focus. PPR 2 covers an evaluation of specified intervention or setting within the local authority which aims to tackle the underachievement of vulnerable groups, promoting inclusion and reducing social inclusion. In this case, for Looked After Children (LAC). PPR 3 is an account and evaluation of the role of the EP in a multi agency project aiming to address the needs of children and families of prisoners. PPR 4 is a reflective account of the role of the EP in supporting children who have an acquired brain injury. During the last years, I have developed a particular interest in neuropsychology and how EPs can use up to date evidence and research from neuropsychology to inform their practice. Whilst the number of children who have severe acquired brain injuries is relatively low, the nature and extent of their injuries can often be incredibly complex and lifelong. I therefore wrote this PPR with a view to gain more specialist knowledge in the area of brain injury, procedures and provision for children and families whose lives are affected by an acquired brain injury. This PPR 4 fits broadly under the category of a trainee's contribution to a specialised area of work as defined by the university.

1.3.1 Professional Practice Report 1

This report focussed on the assessment and intervention of four boys with social, emotional and behavioural difficulties. The boys all attended the 'Rainbow Room' during the afternoons at school. The Rainbow Room was designed to give children an opportunity to learn and rehearse social skills and engage more positively with peers within this small group. As part of this study, the four pupils received an emotional literacy programme delivered through circle time each afternoon for four weeks. The Emotional Literacy Assessment and

Intervention Ages 7-11 (ELAI, Faupel, 2003) measure was used as a pre and post test. This measure breaks down emotional literacy into five sub skills in alignment with Salovey and Mayor's (1990) original definition of emotional intelligence. They are as follows: empathy, motivation, self regulation, self awareness and social skills. The ELAI was completed by the pupils, teachers and parents at the beginning of the study in order to identify the specific needs of the group and design circle time content around those needs and also to act as a baseline measure to evaluate any progress that the group may make. Data from the ELAI completed by parents suggested that the overall emotional literacy of children taking part in the intervention had increased. However, additional interview with teaching staff suggested that these gains had not always generalised to the classroom and often they were uninformed of the type of work and interventions that the children had received in the Rainbow Room. The main conclusion from this report was that where small group interventions do happen in school, there needs to be effective and explicit mechanisms to communicate with teaching staff with the view to support children in generalising these newly acquired skills. This therefore raises the importance of effective communication at a whole system level.

1.3.2 Professional Practice Report 2

The authority in which I work has a designed team for Looked After Children (LAC), there are currently four specialist EPs working on a part time basis for this team. LAC are a vulnerable group within society and demonstrate lower educational attainment that other children nationally. In 2008, just 14% of children looked after continuously for at least 12 months obtained at least 5 GCSE's or GNVQ at grades A*-C compared to 65% of all school children (Statistical first release, DfCSF, 2008). Increasing the attainment of LAC is therefore

a national priority with services investing a lot of time and money into supporting the needs of these children. This report was an investigation into how one local authority seek to raise the achievement of LAC. I interviewed several professionals who work with LAC. A thematic analysis was conducted and demonstrated six key themes; attendance, stability of placements, training, the role of the EP, projects, and care homes. Interviewees felt that the instability of care placements was still an issue for LAC and that overall the outcomes for those in foster care were better than for those who attended children's homes. It is recommended that the government need to ensure the stability of care placements at both a national and local level and do their utmost to ensure that children are placed with foster carers rather than in care homes. There are also implications for the type of work that EPs engage in and the role that EPs might take during annual review and transition meetings.

1.3.3 Professional Practice Report 3

Between 125,000-170,000 children and young people are affected by parental imprisonment each year in England and Wales (Murray, 2007). Around 65% of children of prisoners will go onto offend themselves (Glover, 2009) and are likely to experience a range of adverse outcomes that may affect their social and emotional development and overall quality of life. This report is a reflective piece on the role of the EP in a local multi-agency project aiming to enhance positive outcomes for children and families of prisoners. The RADIO framework was used to describe the key elements of the project and how actions were negotiated and evaluated. This assignment highlights the unique contribution that EPs can bring to a multi professional project, namely an up to date knowledge of typical and atypical child development, an up to date knowledge of research findings, the

application of research skills and an ability to gain views of children and young people in authentic and genuine ways.

1.3.4 Professional Practice report 4

My final PPR reported an investigation into how EPs can support the reintegration of children who have an ABI from rehabilitation back to full time education. I interviewed a range of professionals from two different settings, a specialist rehabilitation centre for children with acquired brain injury and a local children's hospital. The aim of the interviews was to explore the rehabilitation process of children who have had an ABI with a particular focus on how EPs from the local authority might support this process. Semi structured interviews were used; the interviews were transcribed and analysed using thematic analysis (Braun & Clarke, 2006). Several key themes were generated from the data. With regards to the role of the EP in supporting the rehabilitation process for children who have had an ABI, the following sub themes were identified: attending discharge meetings, translating medical reports, training school staff about the needs of children with an ABI, raising awareness and monitoring the progress of children with an ABI, liaising with rehabilitation teams, knowledge of local provisions, coordinating and facilitating meetings and providing a further resource in the community after children have been discharged from specialised rehabilitation. It was thought that EPS' would benefit from having at least one EP who specialised in neuropsychology and the implications of an ABI and that the initial doctoral training course for EPs should include a module on typical and atypical brain development. Key actions are recommended for EPs and EPS' in order to develop their capacity to meet the needs of children who have had an ABI (mild, moderate or severe) and the needs of their families.

1.4 Professional development

As a TEP, I have been presented with a range of opportunities to extend both my academic skills and professional knowledge and experience. The PPRs that I have completed have provided me with an opportunity to gain an in-depth knowledge of both psychological theories and interventions but also research methods and methods of analysis that I have since continued to use within my practice. The PPRs have allowed me to develop specific areas of interest and as a result I have undertaken further work within the service around both supporting the needs of children of prisoners and supporting schools in understanding brain development, the impact of an acquired brain injury and educational requirements for those children and young people that have experienced a brain injury. Completing the PPRs as part of the university's academic requirements has therefore had a direct practical impact on my work and outcomes for children, young people and their families.

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CHAPTER 2- PROFESSIONAL PRACTICE REPORT 1

2.1 Title

An evaluation of the implementation and the effectiveness of circle time for a small group of primary aged children who had been receiving an alterative curriculum in a mainstream school.

2.2 Abstract

Four primary aged boys had been receiving an alterative curriculum in a mainstream school. They attended a group called the Rainbow Room which was led by an experienced teaching assistant for four afternoons per week. There were diverse needs within the group, including emotional and behavioural difficulties and autistic spectrum disorder. During a planning meeting, the SENCO had expressed a need for support in the delivery of circle time within the Rainbow Room with a focus on enhancing emotional literacy and wellbeing. As part of this study, the four pupils received an emotional literacy programme delivered through circle time each afternoon for four weeks. The Emotional Literacy Assessment and Intervention Ages 7-11 (ELAI, Faupel, 2003) measure was used as a pre and post test. This measure breaks down emotional literacy into five sub skills in alignment with Salovey and Mayor's (1990) original definition of emotional intelligence. They are as follows: empathy, motivation, self regulation, self awareness and social skills. The ELAI was completed by the pupils, teachers and parents at the beginning of the study in order to identify the specific needs of the group and design circle time content around those needs and also to act as a baseline measure to evaluate any progress that the group may make. Data from the ELAI completed by parents suggested that the overall emotional literacy of children taking part in the intervention had increased although it is difficult to conclude that this was primarily due to the circle time intervention.

Whilst there was some anecdotal evidence to suggest improvements in children's emotional literacy, data from interviews with teaching staff suggested that explicit strategies to promote the generalisation of skills to the classroom were absent. Future work in this area should therefore carefully consider the communication mechanisms between small group work and the classroom to promote opportunities for generalisation within the classroom setting.

2.3 Introduction

In 2007, a UNICEF report on the wellbeing of children living in developed countries was published. The report documented that children in the UK were at the bottom of the league, suggesting that the emotional wellbeing of children and young people in the UK is far from that which we would expect in comparison to other similar or less wealthy countries.

The emotional wellbeing of children and young people is therefore a key priority for the government, local authorities and schools in the UK who are increasingly looking for ways to enhance emotional wellbeing.

2.3.1 What is emotional literacy?

Goleman (1996) defined emotional intelligence as the ability to recognise and understand ones own emotions and those of others, to manage one's emotions and to express them appropriately. The term "emotional intelligence" originated from the work of Salovey & Mayer (1990) who particularly focused on its cognitive and behaviour aspects and the links between neurology and emotional intelligence. The concept and use of emotional intelligence

within an educational context and more widely, the workplace was largely popularised by the work of Goleman (1998). Goleman argued that children's IQ scores are increasing due to factors such as better nutrition, better schooling, computer games, puzzles and smaller family sizes. However as children grow ever smarter in IQ, their emotional intelligence is on the decline. Goleman (1998) found that on average, children are growing more lonely and depressed, more angry and unruly, more nervous and prone to worry, more impulsive and aggressive. Goleman (1998) therefore claimed that emotional intelligence is more important than IQ for children and adults alike and that emotional intelligence determines our potential for learning the practical skills that are based on its five elements:

- Social awareness- Knowing one's internal states, preferences, resources and intuitions.
- Motivation- Emotional tendencies that guide or facilitate reaching goals
- Self regulation- Managing ones internal states, impulses and resources
- Empathy- Awareness of others' feelings, needs and concerns
- Social skills- adeptness at inducing desirable responses in others.

Goleman (1998) also believes that emotional intelligence is not something that is fixed but rather a combination of skills that can be learned and developed over time. Such skills are therefore responsive to intervention.

As the emphasis on emotional intelligence has gained more credibility in recent years amongst authorities and schools, there have been numerous definitions of the term, for example, social and emotional wellbeing, personal and social competence, emotional and

social competence, mental health and emotional literacy. Many of these terms are used to describe the same subset of skills that Goleman (1998) originally defined as the concept of emotional intelligence and can be used interchangeably. However, for the purpose of this essay the term emotional literacy will be used. The term emotional literacy has grown to be more meaningful in an educational context and is now popular with and much used by Educational Psychologists, schools and local authorities within the UK (Weare & Gray, 2003).

Within the context of this essay, emotional literacy is therefore defined as:

'The ability for people to recognise, understand, handle, appropriately express their own and to recognise, understand and respond appropriately to the expressed emotions of others' (Faupel, 2003: 3).

This definition is a working definition from Southampton's Educational psychology service who have placed a great emphasis on promoting emotional literacy within the area. Southampton's EPS also designed the assessment measure used as part of this study which corresponds with their working definition. In addition this definition derives from Goleman's work and is the same as the definition used by the DfES in the Social and Emotional Aspects of Learning (SEAL) curriculum guidance (2005).

2.4 Identifying a need

In 2003, the DfES commissioned a study into how a child's emotional and social competence and wellbeing could be developed more effectively. The study consisted of a literature review, cases studies and interviews with professionals across the UK (Weare & Gray, 2003). In gathering data from Local Education Authorities (LEAs), the project sought to explore what those on the 'frontline' were already doing and also to identify good practice, barriers to implementing programmes promoting emotional literacy and ways to build capacity. One of the key findings from this study was that there is a strong consensus in the literature, from experts in the field such as Elias et al (1995, 1997), The Collaborative Centre for the Advancement of Social and Emotional learning (CASEL) and from leaders in the LEAs that work on social competence and wellbeing, that this has to be high profile across schools in the UK (Weare & Gray, 2003). (See Figure 1 for other key recommendations).

Figure 1: Key recommendations from Weare & Gray, 2003.

Within school

- There is strong international evidence to suggest that a whole school approach to social and emotional competence and wellbeing is vital and necessary to complement more targeted and focused small group work
- Any programme of work should take an holistic and developmental approach
- Schools also need to create warm and encouraging environments for both pupils and staff
- Schools should introduce explicit teaching and learning programmes
- Teachers competence and wellbeing also need to be promoted

Within the community

- Interventions should involve parents and families

Within the LEA

- The DfES, LEAs and schools should attempt to evaluate work on emotional and social competence and wellbeing using a variety of methods, data and perspectives that involve users and encourage self evaluation.

In response to this research, the Primary National Strategy published the Social and Emotional Aspects of Learning (SEAL) curriculum (Primary National Strategy, 2005). SEAL is a whole school approach delivered as a spiral curriculum which recognises key developmental stages within a child's social and emotional development. SEAL also has activities designed to enhance staff's social and emotional wellbeing and is an explicit teaching programme aimed to address the social and emotional aspects of learning.

Silver SEAL is a set of materials specifically designed for small groups of children who need additional help to develop their social, emotional and behavioural skills and who may not feel comfortable to contribute ideas around this area at a whole class level. The delivery of the SEAL curriculum adheres to the 'waves of intervention' model proposed by the DCSF (DCSF, 2010). Silver SEAL is the equivalent of a wave two intervention, that is, a targeted small group intervention for pupils who can be expected to catch up with their peers (DCSF, 2010). This intervention is based on the idea that some children will benefit from further exploring and extending their social, emotional and behavioural skills by being a member of a small supportive group facilitated by a key empathetic and nurturing adult (Primary National Strategy, 2006).

2. 5 An alternative perspective

The SEAL curriculum and the ideas behind promoting emotional literacy in a systematic and programmatic approach have been widely criticised by authors such as Craig (2007) Ecclestone (2007) and Ecclestone & Hayes (2009). Craig (2007) argues several key points against the use of SEAL in schools, firstly, that there is a weak rationale and evidence base for

SEAL. The idea of teaching emotional literacy to all children across schools is a systematic developmental way is something that has not been tried before and yet there have not been any large scale evaluations to measure the outcomes for children. Moreover, SEAL is now being 'rolled out' to secondary schools without any evidence of positive outcomes from primary SEAL. Attempts to evaluate SEAL have largely produced anecdotal evidence from teachers and students which does not seem sufficient to justify the investment of millions of pounds. The DCSF explicitly claim that both primary and secondary SEAL are based on the work of Goleman. Goleman's claims around the importance of emotional intelligence have been discredited, his ideas on what an emotionally intelligent child might be like are based on subjective value- laden and culturally bound ideas that children are expected to internalise into their own emotional and behavioural dispositions (Rietti, 2008).

The SEAL curriculum also encourages children to display and discuss their emotions and success is measured by one's ability to do so. In essence, there are a list of desirable characteristics and behaviours against which all children will be judged. Craig (2007) argues that the programme is in danger of engineering children's personalities to a precise template moulded by the values and judgments of the authors rather than a scientifically robust evidence base. In addition the values and skills promoted by SEAL are culturally bound; for example Western ideals such as assertiveness and open self expression may well strike someone with more authoritarian ideals of child raising as bordering on rudeness (Rietti, 2008).

Whilst the theoretical rationale behind the introduction of SEAL seems to have a 'common sense' approach, the actual scientifically robust evidence base is lacking and therefore the

criticisms of employing this intervention on such a mass scale seem well founded. However the development of overall interventions and support to enhance positive mental wellbeing such as an increase in Children and Adolescents Mental health Services is based on a much wider and robust evidence base (Wolpert et al, 2002, 2006) which could also be used to contribute to the rationale of the development of SEAL.

2. 6 Targeted group interventions

There have been a number of reviews to evaluate the effectiveness of small group interventions aiming to enhance children's emotional literacy, although these have primarily been conducted in the United States. For example Greenberg et al (2005) suggested that such programmes were capable of leading to improvements in the following areas:

- Interpersonal skills
- Quality of peer and adult relationships
- Academic achievement
- A reduction in substance abuse
- A reduction in high risk sexual behaviour and
- A reduction in aggressive behaviour

Humphrey et al (2008) conducted a recent evaluation of small group work within the SEAL curriculum. They were interested to assess the impact of small group work on children's social and emotional skills in Key Stages 1 and 3. They conducted interviews with local authority officers, staff and pupils from five schools. They also completed quantitative

evaluations across 37 primary schools and. This included the use of the ELAI to measure emotional literacy. They found that there was statistically significant evidence that primary Silver SEAL small group work has a positive impact for some of the key themes. In addition, the measured impact of the interventions was sustained over a seven week period when a follow up measure was taken.

However the evaluation was conducted using case studies of five primary schools that had been nominated as lead practice schools by their local authorities and thus their study is one that is subject to selector bias; that is by hand picking successful schools the evaluation is more likely to portray Silver SEAL in a positive light. In addition, there were no control groups used as part of this evaluation, which makes it difficult to establish a causal effect of Silver SEAL.

Staff and pupils also suggested that the small group work had a positive impact upon the social and emotional skills of pupils, and there was evidence to suggest that these skills were sustained outside of the small group environment. This was most evident where explicit strategies had been put in place to ensure and support the generalisation of these skills. However, Lendrum et al (2009) state that 'there was a general feeling from staff and pupils that the small group work had a positive impact upon pupils' social and emotional skills'. Whilst the direction of results may appear to be positive, a 'general feeling' does not provide us with a sufficient evidence base for the use of silver SEAL in primary schools across the UK. Several other key points were taken from the evaluation (as shown in Figure 2):

- Successful implementation was influenced by existing work within a given school.
- The skills, knowledge and experience of the small group facilitator were crucial.
- Key barriers to success include attitudes of staff, misconceptions about the nature and purpose of the small group work.
- The success of SEAL small group work was influenced by a range of factors such as the skills and experience of the facilitator and the availability of an appropriate physical space.

***Figure 2*: Key points from Humphrey et al (2008) evaluation of Silver SEAL.**

2.7 Findings from the literature about the effectiveness of targeted interventions

As mentioned previously, the evidence base from the evaluation of targeted interventions to promote emotional literacy in the UK is sparse, with most of the existing evidence originating from studies conducted within the United States. However Curtis & Norgate (2007) evaluated the effectives of a programme called PATHS (Promoting Alterative Thinking Strategies) which is designed to promote social and emotional thinking in primary aged pupils. The PATHS curriculum includes lessons on readiness and self control, feelings and relationships and problem solving. These topic areas are similar to those identified and delivered to the pupils in the current study. Curtis and Norgate (2007) used the Strengths and Difficulties Questionnaire (Goodman, 1997, 1998) and teacher interviews as a way of evaluating the impact of small group work on the social and emotional skills of the participants and drew the following conclusions:

- Compared to children within control schools the children at the PATHS schools showed significant improvements on all five behavioural and emotional constructs from the SDQ.

In addition information from interviews with teachers suggested that they also concluded that the children were showing greater cooperation, empathy and self control.

Shucksmith (1997) conducted a systematic review of pupils who have been involved in a range of targeted interventions. The children involved in the interventions displayed a range of behaviours and profiles, some were chosen to be part of the interventions due to externalising behaviours such as aggression, and others due to internalising behaviour such as anxiety or withdrawal.

The two key findings from this review were:

- The vast majority of interventions last for more than one year
- There is considerable evidence that multi component interventions which offer a mix of CBT, social skills training, attribution training, training of teachers and parents are the most effective content for such interventions.

Hallam, Rhamie and Shaw (2006) also conducted an evaluation of small group work as part of the Behaviour and Attendance Pilot. The small group work was delivered over one term and focused on the development of empathy, social skills, understanding and managing feelings. They found that:

- The success of small group interventions was dependent on the engagement of parents, staff and children working together
- The work being seen as embedded within a larger programme was also crucial to successful outcomes
- There were concerns about the lack of follow up work
- Attitudes of staff were a barrier in some cases as schools did not always perceive any benefit of small group work for certain children and some even viewed it as a punishment for children viewed as naughty.

Hallam et al (2006) also reported that in some cases, children reported more negative statements about themselves after the intervention, perhaps because their attention had been drawn more closely to understanding negative feelings. Hallam et al (2006) suggest that this may be due to increasing age and self awareness, but conclude that 'without a control group it is not possible to conclude with absolute certainty that the negative changes in attitudes occurred as a result of increasing age' (P.96).

This research was funded by the DfES who concluded that the pilot was a success and subsequently went on to invest £10 million on the development of SEAL.

In sum, the implementation of SEAL has been widely criticised, namely due to the lack of evaluation that has been undertaken to measure the impact of a systematic and programmatic approach to children's emotional wellbeing. Evaluations of Silver SEAL suggest some positive impact although this research is still in its infancy.

Research from the US suggests some positive impact of small group work to promote the emotional literacy of children with more specific emotional and behavioural needs which suggests that the participation in such small group work needs to be carefully considered by professionals working with the individual. The evidence base from the UK is still developing; whilst there are some interesting findings about implementing small group work in a school, less is known about the impact of such work on individual children and young people. The aim of my own intervention based on the work of Faupel (2003) was to add to the UK evidence based practice through a small group intervention which utilised a Circle Time Approach.

2.8 What is circle time?

Circle time is one example of a vehicle for the delivery of interventions focusing on the development of social and emotional skills. Circle time involves activities aimed at developing pupils' awareness of themselves and of others, raising self esteem and promoting mutual trust, listening skills and positive interpersonal behaviours. A basic tenet of circle time is that all participants are equal and each contribution is equally valued (Canney & Bryne 2006). Through the use of circle time, it is claimed that children begin to recognise how their emotions and actions are affected by others and how the emotions and actions of others affect them (Lang, 1998). This is a prerequisite skill for the development of emotional literacy according to Faupel's (2002) working definition**.**

Jenny Mosley (1996) is a key U.K. researcher in the area of circle time, who recognises that some children may find it difficult to contribute to circle time at a whole class level and thus

the use of a higher level of therapeutic support for small groups may be beneficial. The content of these sessions is adapted to the needs of the group, e.g. more intense work around social skills, shorter duration, emphasis on the experience of successful participation.

Mosley (1996) recommends that circle time should be carried out once per week for approximately 30-45, minutes although "circle rituals" should occur on a daily basis for a much briefer period. When circle time is initially introduced to a group, group rules should be established. Teachers and children need to agree:

- to signal if they wish to speak;
- not to use any put downs towards each other;
- not to interrupt when someone else is talking;
- that a child has the right to say 'pass' in a round if they do not wish to speak;
- that children who pass in the initial round will, at the end of the round, be allowed to signal if they would like a second chance; and
- not to name anyone in the circle in a negative way (Mosley, 1996)

Clear sanctions will also be needed if children do break the group rules, for example: two warnings and then a time out of circle time. Circle time usually involves one or two warm up games, a round, an activity and a closing (Curry & Bromfield, 1994) and can last up to 45 minutes depending on varying levels of concentration.

2.8.1 What is the research base for the use of circle time?

The circle time literature claims that there is a range of psychological benefits arising from circle time such as the development of self esteem, language and interactive skills, intellectual development, social awareness, cooperation, group functioning, problems solving, decision making and motor development (Kelly, 1999; Moss & Wilson, 1998: Tew, 1998; Wooster & Carson, 1982; Lown, 2002). Many of these processes are integral to the development of emotional literacy. However the actual research base to support such claimed benefits of circle time is sparse, with only a few studies focusing on quantitative systematic measures of the impact of circle time.

One study based in Italy used an experimental methodology comprising 751 pupils aged 11-14 who participated in circle time sessions (Francescato, 1998). Pre and post test scores on a standardised measure indicated improvements in several personal and interpersonal aspects, including self esteem. However the teachers delivering these sessions had also received training about teacher effectiveness and psycho-motor exercises aimed at improving children's ability to cope with their feelings and thus it is difficult to separate the effects of circle time alone.

Miller and Moran (2007) evaluated the effectiveness of circle time with specific reference to the enhancement of self esteem. They used Rosenberg's Self Esteem Scale (RSE, Rosenberg, 1965) and a modified version of Tafarodi and Swann's (1995) measures of self esteem, self competence and self liking. They found that there were statistically significant differences on

both measures of self esteem for the group that received circle time once a day for a four month period compared to a control group who did not receive the intervention.

Whilst common sense might tell us that the idea of sitting in circle and learning skills such as problem solving, expressing feelings and cooperation together would have a positive impact of children's emotional development, the actual evidence base in the UK is sparse and needs to be elaborated further in the future.

The literature review demonstrates that there are some positive effects of small group work, although the studies found were not as scientifically robust as one might hope, in most cases they did not use a control group and so it is difficult to establish causality. Taking ideas from the literature review on both the implementation of small group work aiming to enhance emotional literacy and circle time, I decided to combine the two and design a specific intervention for four boys with particular social and emotional needs as identified by school staff and the assessment measure (ELAI, Faupel, 2003).

2.9 The research context

The present study is an evaluation of the effectiveness of an emotional literacy intervention delivered through the use of circle time for four boys in a mainstream primary school who had been identified as having particular social and emotional needs, one of which had been excluded several times for aggressive and disruptive behaviour and described as on the verge of permanent exclusion.

The school is an average sized primary school in the West Midlands, the vast majority of pupils are of white British heritage with only a small number of ethnic minority pupils. There are 229 pupils on the school register, 14.4% of whom have a statement, of Special Educational Needs or are supported at School Action Plus on the Code of Practice (Code of Practice, 2001). The school therefore have a higher than average number of pupils with additional needs. The school also has a higher than average number of pupils who are eligible for free school meals. A recent Ofsted report found that the personal development and wellbeing of children in the school was good and the overall quality of provision was satisfactory (Ofsted, 2008).

The school had decided to offer an alterative curriculum to the individuals above through the use of what they have called the 'Rainbow Room'. The Rainbow Room is a room located within the school where the four boys go for four afternoons per week The Rainbow Room was approved by the head teacher in July 2008, although the nature and purposes of the room appeared to me to have been somewhat vague and to be susceptible to change on a regular basis. However, what was clear from the outset of the project was that there needed to be enhanced support for the children's social and emotional development.

I am a Trainee Educational Psychologist who has been employed by Educational Psychology Service and working with the primary school since September 2009. At an initial planning meeting the SENCO had expressed a need for support with the delivery of circle time with a focus on enhancing the children's emotional literacy and wellbeing.The teacher had believed that this may support the structure of the afternoon more generally and promote emotional literacy throughout the rainbow room.

2.9.1 Research questions

The research questions in this study which were derived from the literature review focusing on the development of emotional literacy delivered through the use of circle time for small groups of children identified as being 'at risk' of developing social and emotional difficulties are as follows:

1. Is there a positive impact of activities focusing on the development of key areas of emotional literacy when delivered through the use of circle time as perceived by the children in the group, class teachers and parents?

2. What are the views of class teachers and the facilitator about the effectiveness and implementation of an emotional literacy programme delivered through the use of circle time for the four boys in the study attending the rainbow room?

2.10 Methodology- Participants

Four primary aged boys participated in the study. The Emotional Literacy Assessment and Intervention ages 7-11 (See measures section for further details) was used as a pre measure to assess the emotional literacy of each participant. The results from this measure also indicated individual needs within the group and was then used to determined the precise content of the circle time sessions.

The class teachers of each of the boys were also interviewed at the end of the intervention to gain their views around the process and the generalisation of skills. The facilitator was also interviewed to gain her views around both the barriers and the facilitator factors that helped the group to run.

2.11 Measures

The Emotional Literacy Assessment and Intervention ages 7-11 (ELAI, see Appendix 1) was used as a measure of emotional literacy for the purposes of this study. The ELAI was developed by Southampton's Educational Psychology Service and provides indices of children's self awareness, self regulation, motivation, empathy and social skills. The purpose of the tool is to discover where pupils' strengths and weaknesses lie within the area of emotional literacy, in order to provide a better understanding of these competences and, where necessary to highlight areas for intervention (Faupel, 2003). Three standardised checklists enable the user to assess emotional literacy according to the perceptions of teachers, parents and young people themselves. The information gained was therefore triangulated to ensure that each pupil's needs were identified consistently from differing perspectives.

For the purposes of this study, the assessment was used as a baseline measure before the delivery of a circle time intervention specifically designed to meet the needs of four pupil, and again post intervention. The assessment was therefore conducted as a pre test and post test and was completed by the pupil, the pupil's class teacher and parents at both times.

The measure consists of a series of statements (eg. 'I am easily hurt by what others say about me') to which the respondent indicates a level of agreement on a four point Likert scale. There are three versions of the questionnaire for pupils, teachers and parents which all vary slightly in length, the type of questions asked and scoring. The questionnaire can be completed on a computer using the ELAI CD-Rom or on paper. For the children's version, the questionnaire can be completed using an interactive programme on the computer which repeats the questions out loud and shows characters that help the child to choose a response. In the event, all of the pupils completed the questionnaire using the interactive version as it was thought that this would be the most accessible, fun and engaging way of gaining their views of their own emotional literacy skills.

The ELAI was considered to be a suitable measure for a number of reasons as summarised in Figure 3.

2.12 Interviews with the facilitator and class teachers

A combination of both quantitative and qualitative data adds to the strength of an evaluation and so semi-structured interviews were also carried out with the Rainbow Room group facilitator and class teachers (please see Appendix 2 for interview schedule).Robson (2002) describes semi structured interviews as an interview that has predetermined questions although the order can be modified based upon the interviewer's perception of what seems most appropriate. Question wording can be changed and explanations given, particular questions which seem inappropriate with a particular interviewee can be omitted, or additional ones included.

- A recent evaluation of small group work using the silver SEAL curriculum (Humphrey et al, 2008) used the ELAI measure. They were looking to measure the impact of small group work using lesson plans from the SEAL curriculum on social skills, motivation, empathy, self regulation and overall emotional literacy for primary aged children. The small group work conducted in the current study is underlined by principles from SEAL and integrated some of the activities from silver SEAL into the programme. The current study also aimed to evaluate the impact of small group work on social skills, motivation, empathy, self regulation and overall emotional literacy, and so I thought that this would be an suitable measure.
- The measure derives directly from Goleman's (1995) model of emotional intelligence.
- The measure corresponds directly with the definition of social and emotional skills provided by the DfES as detailed in the introduction.
- The measure allows for the triangulation of data which provides a more reliable view of a child's needs within their individual contexts.
- The measure is accessible and engaging for children and is therefore an appropriate tool for gaining children's views about emotional literacy and specifically, their own perceived ability to identify and deal with their own emotions and communicate these with others effectively.
- The ELAI is internally consistent. Reliability was assessed using Cronbach's Alpha which revealed coefficients of between .70-.94 for the teacher's checklist, .58- .87 for the parent checklist and .34-.76 for the pupil checklist. The reliability for the pupil's checklist is distinctly lower than that of the parents and teachers and for this reason, a decision was made to provide subscale scores and cut offs for parents and teachers but not for pupils. However the reliability co-efficients for overall emotional literacy for pupils, teachers and parents were 0.76, .94 and .87, respectively and therefore deemed as internally consistent.
- The ELAI has also been demonstrated to have good construct validity using principal components analysis.

***Figure 3*: A summary of the rationale behind the use of the ELAI measure.**

The interview is a flexible and adaptable way of finding things out. Face to face interviews offer the possibility of modifying one's lines of enquiry. Responses can be followed up in more detail and non verbal cues can be detected which may provide a more accurate perception of the individual's constructs and feelings towards a particular subject. Such

responses may not be detected in self administered questionnaires or interviews conducted over the telephone (Robson, 2002).

Semi structured interviews allow the person being interviewed to be much more flexible in their response (Miller & Crabtree, 1999), they also allow the researcher to gain an understanding of the interviewees perception and constructions of the world and therefore reflect a social constructivist epistemology. One of the main drawbacks of using an interview in this particular case is the issue of subjectivity. From a social constructivist perspective, each individual has their own constructions of their social environment and when interpreting data from each interview, it may be possible for the interviewer (who is also the researcher) to interpret the data using their own constructions which are likely to be quite different from each of the interviewees. It is therefore important to bear this in mind when analysing the data.

Whilst I did take notes throughout the interviews, the interviews were not formally recorded or transcribed. This was because the data were collected at the end of term and I was keen to keep the discussions informal so as not to add further pressure to staff. General themes did emerge from the data.

The two methods chosen reflect both a quantitative and qualitative methodological approach which derives from two different epistemological stances. The choice of a particular epistemological base leads to a preference for a particular method on the grounds of its greater appropriateness (Bryman, 1984), however in this case I felt that I would gain a richer and more accurate representation of the research area by capitalizing upon the strengths of two

different techniques. Bryman (1984) argues that the relationship between epistemological stance and the method chosen is not always clear. The quality of research may be reduced if one is to restrict their research techniques to one epistemological stance that may have been developed throughout their training and thus leaves little room for the expansion of data collection tools and the quality of data gathered.

2.13 Procedure

The study took place over a period of three months from September 2009 to December 2009 and comprised a number of distinct stages (as shown in Table 1).

Date	**Action**
Oct 2009	Several observations of the group operating without circle time
Oct & Nov 2009	A literature review of the use of circle time and emotional literacy programmes
Nov 2009	Discussions with the teaching assistant around facilitating the group to share ideas, experience and practice.
Nov 2009	The Emotional Literacy Assessment and Intervention Measure (ELAI) was used to measure the emotional literacy (social skills, empathy, motivation, self regulation and self awareness) of participants from their own perspective and that of teachers and parents at the beginning of the study.
Nov	Session plans were then designed based on Mosley's (1993, 1996) model of

2009	circle time using information from the ELAI which helped to identify the collective needs of the group, alongside discussions with teachers and observations.
Nov 2009	I modelled the first circle time session alongside the facilitator
Nov-Dec 2009	Circle time was delivered over a four week period by the facilitator. I met with her on a weekly basis to support and monitor the intervention and observed a session to ensure fidelity of the planned intervention.
Dec 2009	Post intervention completion of ELAI by participants, parents and teachers.
Dec 2009	Class teachers and the facilitator were interviewed to gain an idea of their thoughts about the implementation and effectiveness of the emotional literacy programme delivered through the use of circle time to the boys in the Rainbow Room.

Table 1- A summary of the procedure of the current study.

The ELAI was carried out at the beginning of the study to allow the researcher to design a intervention that would aim to meet the groups' collective needs. The analysis of this data alongside discussions with the facilitator and SENCO revealed four key priority target areas which were as follows (please see Appendix 3 for an example of the pre assessment data from teachers which highlighted some of the areas that the intervention then focused on).

- Self regulation

- Motivation
- Empathy
- Social skills

These were therefore the topic areas that were focused on during the intervention with one week spent on each theme (see Appendix 4 for session plans and content).

Humphrey et al (2009) found that one of the key factors in successful small group work was to use a triangulated referral process. I carefully considered the children's needs in this study using information from parents, teachers, observations and the children themselves. I would argue that this is the key difference between programmes such as silver SEAL which are aimed at introducing emotional literacy to those children who find it difficult to access the same programme at a whole school level, and this particular intervention was very specific to the needs of the four children involved. A drawback of this however is that the results from this small scale study cannot be generalised to other small groups aiming to enhance emotional literacy through the use of circle time. However some of the findings from the semi structured interviews may well be applicable to other school settings and could be used to inform and support the delivery of other circle time type interventions.

2.14 Results

2.14.1 ELAI

As there were only four participants in the study, statistical tests were not performed on the data. However mean scores were compared below and thus provide a general trend in the results (Please see Appendix 5 for a summary of individual scores).

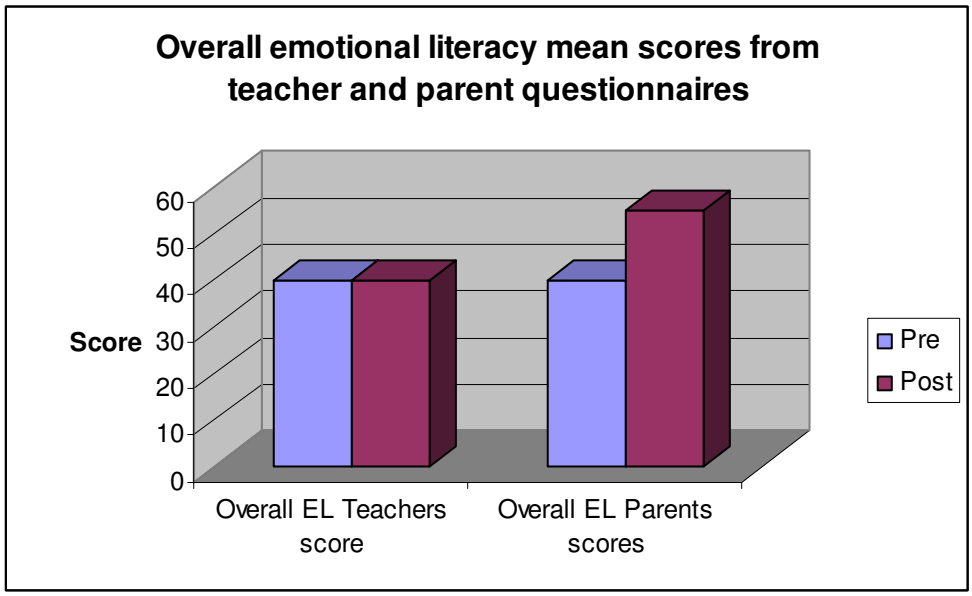

Figure 4. A graph to show overall emotional literacy scores before and after the intervention as perceived by teachers and parents.

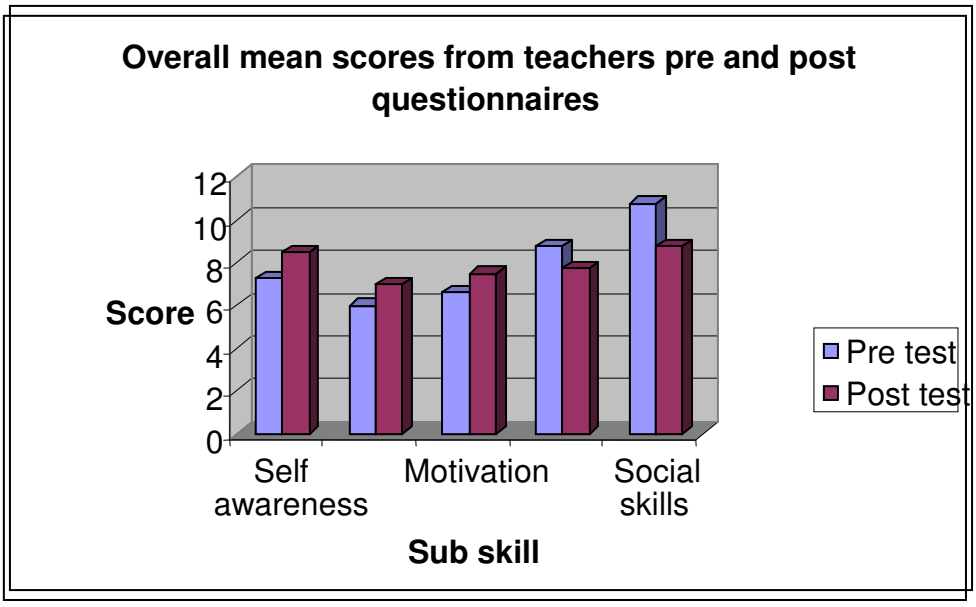

Figure 5. A graph to show the overall mean scores for social awareness, self regulation, motivation, empathy and social skills as measured by the ELAI teacher questionnaire.

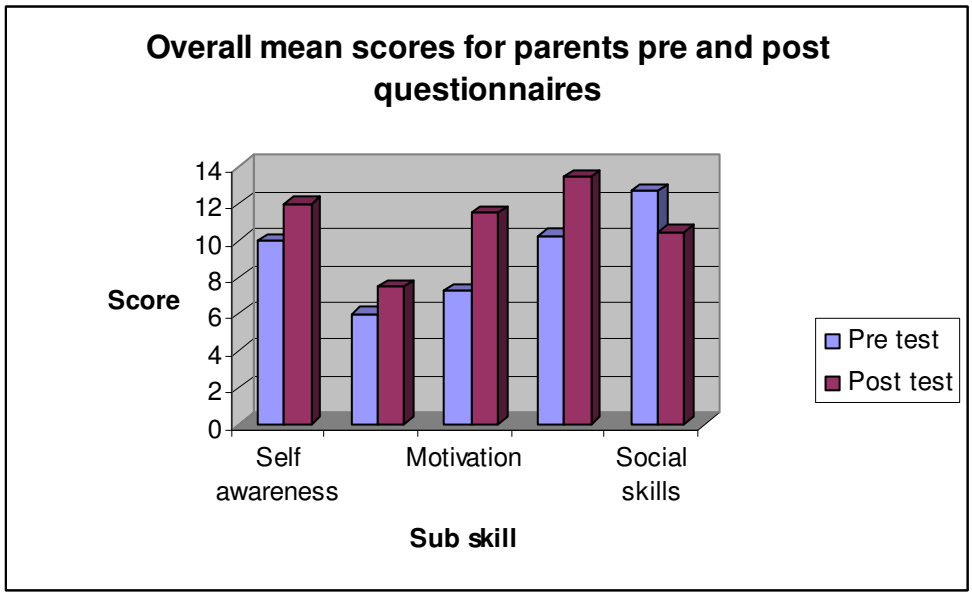

Figure 6. A graph to show the overall mean scores for social awareness, self regulation, motivation, empathy and social skills as measured by the ELAI parent questionnaire.

The reliability analysis from the ELAI assessed the extent to which items in the emotional literacy checklists were measuring the same underlying concept. The reliability of overall emotional literacy and subscale scores was assessed for Pupil, Teacher and Parent checklists. Reliability was assessed using Cronbach's Alpha . The results show that, while the majority of subscales for the Teacher and Parent checklists were reliable, the subscales (such as self awareness) in the Pupil checklist were not. The decision to provide subscale scores and cut-offs for the teacher and parent checklists but not for the pupil checklist was based on these findings (Faupel, 2003). For this reason, the pupil's individual scores have not been reported here.

The results from the pre and post ELAI teachers' questionnaires show a slight improvement in areas of self awareness, self regulation and motivation, although overall emotional literacy stayed the same and scores in empathy and social skills decreased slightly.

Results from the pre and post ELAI parents' questionnaire showed a slight increase in overall emotional literacy, with improvements across self awareness, self regulation, motivation and empathy although a slight decrease in social skills

2.14. 2 Information from teaching staff

I conducted semi structured interviews with the facilitator and three class teachers. I took notes throughout the interviews which were used to identify general themes amongst the views of teaching staff and should therefore be regarded as anecdotal.

Two of the children in the group received the intervention four times per week for four weeks whereas the other two received the intervention three times per week for four weeks. This was because the group that attended the Rainbow Room changed slightly, that is, the original four boys were separated into two groups and other children also joined them. The interpersonal dynamics of the groups may therefore have changed throughout the study. This was a decision that was made by staff at the school. Two of the pupils were part of the group for three days per week as opposed to four. This is a key point to note, one of the most important parts to any intervention in schools is consistency. Unfortunately, in this case the delivery of the intervention to each child was not consistent, which may therefore have impacted upon the results.

Please see Appendix 6 for a more detailed description of the information gained from interviews with the teaching staff. Key points from interviews with the teaching staff are as follows:

- Some of the session plans were too long; children found it difficult to concentrate on circle time for more than 20 minutes.
- There was no bridging to allow the children to generalise their developing skills back into the classroom. Teachers were not made aware of the strategies and content of the sessions which reduced opportunities for the generalisation of skills.
- There was a lack of ownership within the school to administer the strategies taught in the Rainbow Room.

- There was a lack of opportunity for modelling social and emotional skills as there was only one facilitator in the group. This meant that she could not model skills such as turn taking and emotional recognition with another adult.
- The Rainbow room promoted a move towards a more inclusive attitude of other children.
- The facilitator reported an increase in confidence to run circle time after having support from the Educational Psychology Service.

2.15 Discussion

Data from the ELAI parent questionnaires suggest that there was an improvement in pupils' overall emotional literacy after the intervention had taken place, although this was not the case with the data from the teacher questionnaires.

There are a number of factors to consider when looking at this data set; firstly the data were analysed using descriptive statistics and so it is not known whether differences between pre and post test scores are significant. The data from the study therefore only provide information about the direction of change and it's approximate size. Secondly, a control group was not used in this study and so it difficult to identify direct causality. The emotional literacy of the pupils receiving the intervention may have increased due a number of other confounding variables, e.g. work taking place during assemblies, class or at home.

Thirdly, the intervention took place over just a four week period. In their review of a range of small group targeted interventions, Shucksmith et al (1997) found that the majority of

interventions lasted for one year or more. It is not surprising then that there are only small changes were measured over a four week period, some of which may not have been perceived by teachers who are also monitoring thirty other children. The direction of change as perceived by parents is however positive.

In addition, the measure used (ELAI) may not have been sensitive enough to detect discrete changes in behaviours such as social skills and empathy from the perspectives of the children, teachers and parents but rather provides an estimate or overview of their emotional literacy. For example, many behaviours relating to emotional literacy begin with cognition that relates to feelings. Changes at this level would not be detected by the ELAI. Perhaps a more sensitive measure would involve the use of personal construct psychology with individuals to gain an understanding of each child's constructs around skills such as empathy, self regulation etc and see how these may have shifted as a result of the intervention.

Semi structured interviews were used as a way of gaining information from staff about the practical implementation of the programme. I believed that a combination of both qualitative and quantitative data would strengthen the evaluation by providing information about the facilitating factors and possible barriers to implementing an emotional literacy programme within an educational context. Several key themes emerged from interviews with teaching staff, some of which echo the findings from the literature review about the effectiveness of targeted small group work, that is:

- Key barriers to success include attitudes of staff, and misconceptions about the nature and purpose of the small group work (Humprhey et al, 2008).
- The success of small interventions was dependent on the engagement of parents, staff and children working together (Hallam, Rhamie & Shaw, 2006).
- The work being seen as embedded within a larger programme was also crucial to successful outcomes (Hallam, Rhamie & Shaw, 2006).
- There were concerns around the lack of follow up work (Hallam, Rhamie & Shaw, 2006).

In the current study, there was little evidence to suggest that skills learnt were sustained outside of the small group environment. It appears that one of the major barriers to the implementation and success of the intervention in this case was a lack of communication between staff and a lack of ownership for using and promoting strategies learnt within circle time. Taken together, these factors appeared to have prevented the generalisation of skills learnt in circle time to the classroom. Future work should therefore focus on promoting explicit strategies that allow children to bridge the information learnt in a small group context to the classroom. Gillies & Khan (2009) also suggest that teachers need to be mindful of the apparent delay many students experience in being able to transfer the skills of problem solving and reasoning and to provide more instruction and reflection for these skills to emerge. In the classroom then, teachers need to employ techniques that allow for further reflection on those skills taught in the Rainbow Room.

In relation to the initial research questions, there does appear to be a positive impact of small group work aiming to enhance the emotional literacy of pupils through the delivery of circle

time, more so from the perspectives of parents than teachers. The facilitator and class teachers felt that the intervention had been successful although it only ran for four weeks which they felt was not long enough to realise its planned outcomes. In addition strategies were not shared between the Rainbow Room and the rest of school, which compromised the generalisation of skills learnt in the Rainbow Room.

2.16 Recommendations for future work incorporating emotional literacy small group work and circle time include:

- Triangulated data should be used for children taking part in the groups. That is, their needs should be carefully identified through the use of consultation and discussion with the pupils, parents and teachers in the school.
- The intervention needs to be specifically designed to target the needs of those involved. A quantitative measure such as the ELAI will help to determine areas of concern from the pupils, parents and teachers. A qualitative measure will also support the evaluation of such work, perhaps the use techniques derived from Personal Construct Psychology.
- The whole school community need to be aware of the small group work to ensure that other staff can also implement the same strategies.
- The class teacher needs to be aware of the content of each session and plan for explicit opportunities to help the pupil generalise their developing skills into the classroom or around school.
- Parents should also be given the opportunity to develop skills learnt in small group work at home and support the generalisation of such skills.

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2.17 APPENDICES

Appendix 1: A blank copy of the child, teacher and parent's ELAI questionnaires and an example of how the questionnaire was accessed by children on a computer.

Appendix 2: Interview schedule used with the facilitator and adapted for use with staff.

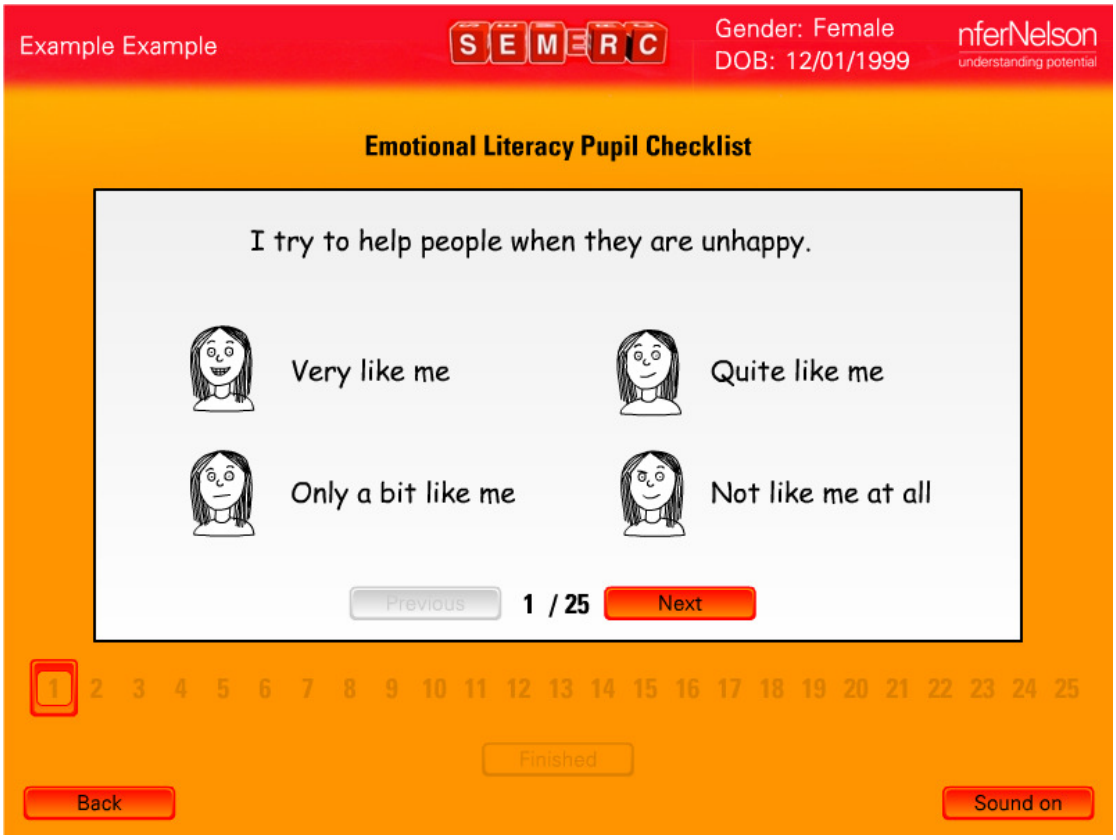
Appendix 3: An example of the pre- assessment data broken down into specific areas from the teacher's questionnaires.

Appendix 4: Session plans for the four week intervention (please not that resources were provided to the school although have not been reproduced here).

Appendix 5: Results from the ELAI questionnaires for parents and teachers.

Appendix 6: A description of the themes identified from interviews with the facilitator of the Rainbow Room and teaching staff.

Appendix 1: An example of how the ELAI questionnaire is accessed by children.



Appendix 2: The interview schedule used with the facilitator of the Rainbow Room. This was adapted for use with class teachers.

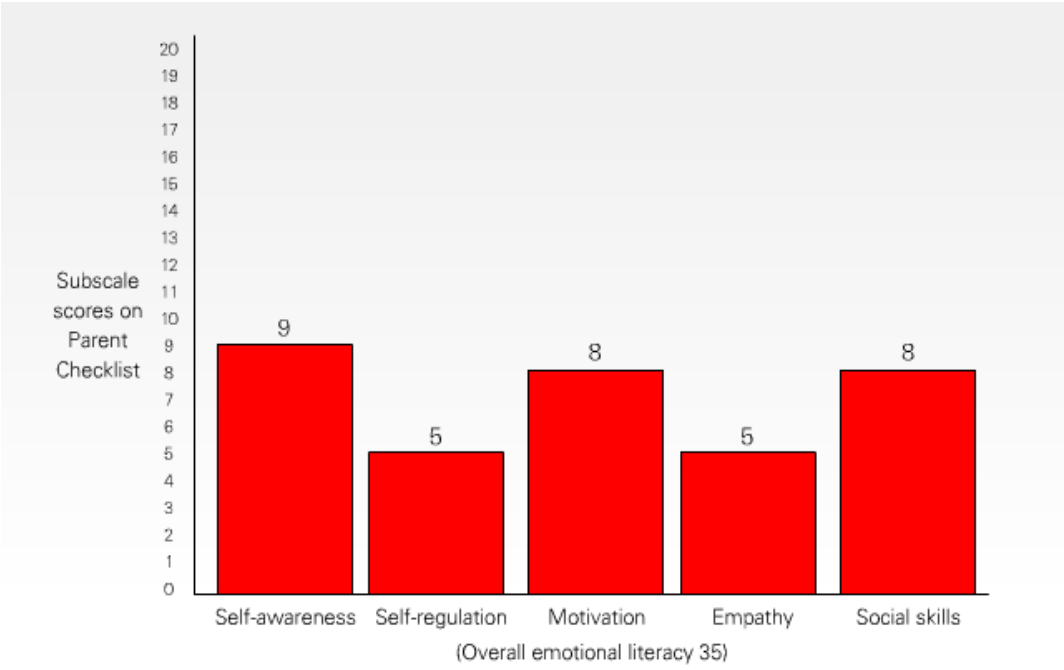
Rainbow Room evaluation- Questions to guide an informal interview 14/12/09

Facilitator:

1. How many times did the children receive the intervention out of a possible 16?
2. Do you feel that circle time has been successful?
3. What impact do you feel that circle time has had on the children involved?
4. What impact has it had on other children?
5. Are there any barriers to implementing circle time in the rainbow room?
6. If so can you identify some of these barriers?
7. Hoe confident would you say you were about running circle time before the intervention began? 1-10
8. How confidant would you say you felt now to run a circle time group again?
9. Did you feel that the assessment measures used were appropriate and accurate?
10. How manageable was the project for you?
11. Is there any other support that you would need to implement the same project again?
12. Are there any other assessment tools that you could use? If not, would you like some?
13. Would you have time to plan other sessions similar to those that were planned by the TEP?

Teachers:

1. Have you noticed any improvements in behaviour around self regulation, motivation, empathy, social skills, developing self awareness?
2. Can you give an example?
3. Were you aware of what was happening in the rainbow room?
4. Were any strategies shared with you?
5. Do you use circle time in class?
6. How does x respond to this
7. Do you feel that X needs circle time in smaller groups?


Subscale scores on Parent Checklist
20
19
18
17
16
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14
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8
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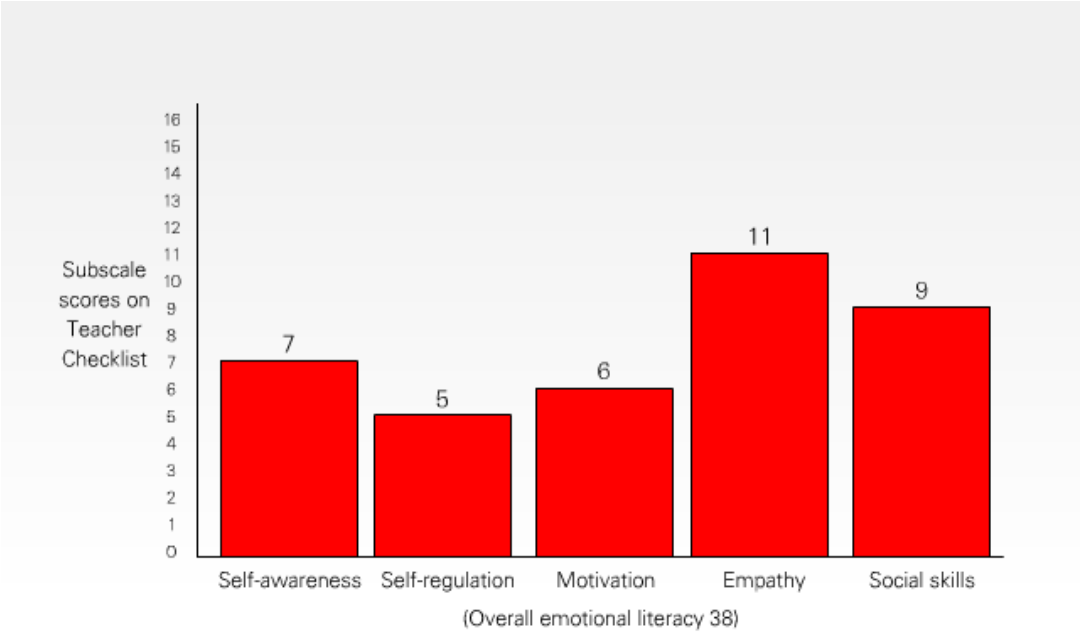
8
Self-awareness
Self-regulation
Motivation
Empathy
Social skills
(Overall emotional literacy 35)


Subscale scores on Teacher Checklist
16
15
14
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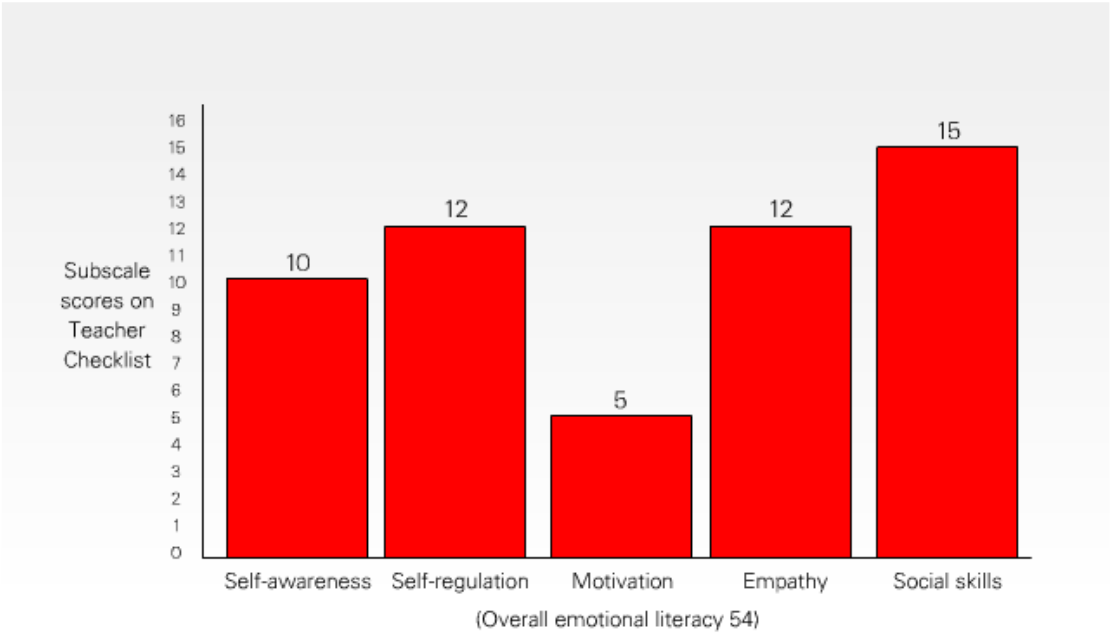
Self-awareness
Self-regulation
Motivation
Empathy
Social skills
(Overall emotional literacy 38)


Subscale scores on Teacher Checklist
16
15
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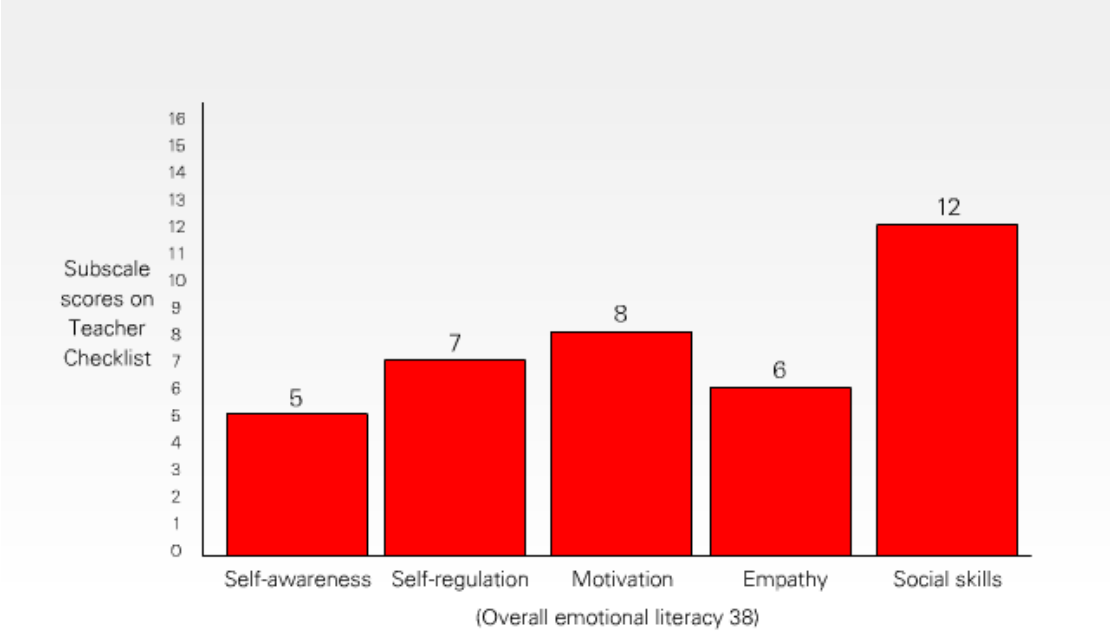
12
15
Self-awareness
Self-regulation
Motivation
Empathy
Social skills
(Overall emotional literacy 54)


Subscale scores on Teacher Checklist
16
15
14
13
12
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1
0
5
7
8
6
12
Self-awareness
Self-regulation
Motivation
Empathy
Social skills
(Overall emotional literacy 38)

Appendix 4: Information shared with the facilitator about circle time and session plans for the four week intervention. These plans were based on findings from the initial ELAI measure and discussions with staff and parents about the needs of each individual participant.

Circle time
KP
The rainbow room
& X's EPS

What is circle time?

Circle time involves activities aimed at developing pupil's awareness of themselves and of others, raising self esteem and promoting mutual trust, listening skills and positive interpersonal behaviours. A basic tenet of circle time is that all participants are equal and each contribution is equally valued. (Canny & Bryne 2006).

Why use circle time?

The very act of sitting in a circle emphasises unity and equality, encouraging attitudes of honesty and trust.

Circle time also encourages children to:

- Feel a sense of belonging
- Express feelings in a calm way

- Learn to develop assertive relationships
- Share thoughts and feelings in a safe environment
- Develop a collective responsibility
- Build a sense of being a team
- Develop social skills
- Enhance self esteem
- Improve listening skills
- Improve behaviour
- Develop language skills
- Co-operate
- Problem solve
- Resolve conflicts together
- And develop their emotional intelligence

Small group work

Mosley (1996) recognises that some children may find it difficult to contribute to circle time at a whole class level and thus the use of a higher level of therapeutic support for small groups may be beneficial.

The content of these sessions is adapted to the needs of the group, e.g. more intense work around social skills, shorter duration, emphasis on the experience of successful participation.

Curry & Bromfield (1994) acknowledge that some children acquire social skills naturally whereas other children may come to school without such skills which my lead to inappropriate interactions with others. Social skills can therefore be taught to children and practiced in the safety of circle time.

What does circle time look like?

Jenny Mosley (1996) recommends that circle time should be carried out once per week for around 30-45 minutes although circle rituals should occur n a daily basis for a much briefer period.

When circle time is initially introduced to a group, group rules should be established. Teachers and children need to agree:

- To signal if they wish to speak
- Not to use any put downs towards each other

- Not to interrupt when someone else is talking
- That a child has the right to say ‘pass’ in a round if they do not wish to speak
- Children who pass in the initial round will, at the end of the round, be allowed to signal if they would like a second chance
- Not to name anyone in the circle in a negative way (Mosley, 1996)

Clear sanctions will also be needed if children do break the group rules, for example: two warnings and then a time out of circle time.

Skills needed by teachers for circle time:

- The ability to listen well
- The ability to be honest sometimes about your own feelings and thoughts
- The ability to use good eye contact and show emotional warmth and empathy
- The ability to recap what children have said and reflect it back to them to show you have understood
- The ability to notice and thank children for the skills that you should focus on in circle time, eg. Thinking, looking, listening, speaking and concentrating (Mosley, 1996).

The format

- The use of pairs or triads is advisable
- The frequency and duration of circle time is governed by varying levels of concentration and the constraints of the curriculum.
- Most circles include 1 or 2 games, a round, an activity and a closing (Curry & Bromfield, 1994)

Circle time planning
Week 1
Session 1 & 2, self regulation

Main aims

- To identify what it means to be angry
- To identify the physiological signs of anger
- To recognise that different people have different signs of anger

	Time taken	**Activity details**
Welcome and check in	2 mins	Use of feeling fans or thumbs up or down. Today we are going to think about how it feels to be angry and what our bodies might do when we feel this way.
Warm up game	5 minutes	Surprise box- Bring in a box with an object from home. Pass the box around and the children should guess what's in the box. The children can ask a question each when the box is in their hands. This can be repeated if no- body guesses after the first round. You can also give clues if the children are struggling to guess.
Activity	10 minutes	Use the object in the box as a tool to be passes round the circle for turn taking. Ask the children to think about when they get angry. What makes them angry? What happens to our bodies? How does it feel? Can you show us on this body? Use the drawing and post it notes to talk about what happens when you feel angry- write on a post it note or use different colours to show where and how you feel angry. Children could also draw on the post it notes to communicate how they feel angry. That's really interesting that x said he has butterflies in his tummy, does anyone else feel that way? If no discuss how we might all feel slightly different when angry. What do you do when you get angry? Can you think of other ways to control our anger?

Warm down	5 minutes	Relaxation activity- breathing by numbers Get the children to try breathing by using their abdomens rather than chest expansion. They can rest a hand on their chest to see the difference. You will need to model this before counting. Say 'I want you to breathe in for four counts and out for six- in, one two, three, four, and out, one, two, three, four, five, six. Do this just five times at first.

Resources

- Box with item in
- Large drawing of body outline
- Post it notes
- Pens
- Paper
- Feeling fans

Circle time planning
Week 1
Session 3 self regulation

Main aims

- To understand that there are different stages of anger
- To understand that there are different triggers and these are often cumulative
- To differentiate personal triggers, signs of anger and the explosion

	Time taken	**Activity details**
Welcome and check in	2 mins	Use of feeling fans or thumbs up or down. Today we are going to think about how it feels to be angry and what our bodies might do when we feel this way.
Warm up game	5 minutes	Surprise box- Bring in a box with an object from home. Pass the box around and the children should guess what's in the box. The children can ask a question each when the box is in their hands. This can be repeated if no- body guesses after the first round. You can also give clues if the children are struggling to guess.
Activity	10 minutes	Use the object in the box as a tool to be passes round the circle for turn taking. Use the fireworks example to show children that we all have different triggers that light our fuses, some fuses burn quicker than others because they are much shorter. The fuse then keeps going and going until we explode. What are your triggers? What makes you angry? What are the signs? What does the explosion look like? You could ask children to draw a picture under each of those headings/pictures to show you what they mean.
Warm down	5 minutes	Relaxation activity- breathing by numbers

		Get the children to try breathing by using their abdomens rather than chest expansion. They can rest a hand on their chest to see the difference. You will need to model this before counting. Say 'I want you to breathe in for four counts and out for six- in, one two, three, four, and out, one, two, three, four, five, six. Do this just five times at first.

Resources

- Box with item in
- Fireworks pictures blown up
- Paper
- Pens

Circle time planning
Week 1
Session 4, self regulation

Main aims

- To look at ways of responding to angry feelings
- Choose a strategy that works best for them
- Use strategy
- Pictures in class and at other times during the day.

	Time taken	**Activity details**
Welcome and check in	2 mins	Use of feeling fans or thumbs up or down. Today we are going to think about how it feels to be angry and what our bodies might do when we feel this way.
Warm up game	5 minutes	Surprise box- Bring in a box with an object from home. Pass the box around and the children should guess what's in the box. The children can ask a question each when the box is in their hands. This can be repeated if no- body guesses after the first round. You can also give clues if the children are struggling to guess.
Activity	10 minutes	Ave a go at the strategies from the hand out.
Warm down	5 minutes	Relaxation activity- breathing by numbers Get the children to try breathing by using their abdomens rather than chest expansion. They can rest a hand on their chest to see the difference. You will need to model this before counting. Say 'I want you to breathe in for four counts and out for six- in, one two, three, four, and out, one, two, three, four, five, six. Do this just five times at first.

Resources

- Box with item in
- Strategies page
- Paper
- Pens

Circle time planning
Week 2
Session 1, motivation

Main aims

- Introduce the concept of motivation
- To be able to say there things that we are good
- Be able to tell you what my strengths are as a learner

	Time taken	Activity details
Welcome and check in	10 min	- Reminder of group rules - Reminder of last weeks work - Has anyone needed to use the calming down strategies - Quick reminder of what they were - Today's plan and main aim ' to look at what motivation means to us and to be able to tell each other what things we are good at' - 1-5 rating, how are you feeling?
Warm up game	5 minutes	Rounds- Use an object such as a cuddly toy to pas round the circle. Each child is asked to complete the round when they are holding the item. Rounds such as: I feel good in school when.... I am happy to learn in school when.... I am good at .... Person next to me is good at..... I am happy to come to school when.... One of my happiest memories of school is....
Activity	10 minutes	Use the cuddly toy, make him look sat, ie, head down etc or use a picture of a sad person (SEAL resources). Explain that he feels sad because he feels that he is not good at anything so what's the point of working. Explain that you think he is a very good learner and he is

		good at lots of things in class, but today he can only think of the things he is not very good at. Explain that it might help if the children tell the toy some of the things that they can do. Use stars or tokens an 'I can cards'. Ask the children to write or draw things that they are good at and then ask them to post the token in the 'we can' tin. The ask each child to pick an item from the tin and read it oit to the class (support as necessary with reading). All children in the group who feel they can do the same, stand up. Collect the 'I can' tokens back in the 'we can' tin.
Warm down	5 minutes	Relaxation activity- visualisation scripts. Ask the children to either lie down or sit comfortably, close their eyes if they wish and listen carefully to the words. You can either read the scripts or make one up about a child's special place. Ask them to imagine a place that they feel safe and happy, what is around them, who is there. This should be in the heads and not really something that all children might feel comfortable to share. You can explain that some examples of a happy place may be in their bedrooms at home or in the car with a parent. Think of your own safe place and questions one could ask to elicit the context of that place. Review the learning aim of the day. Could use the ladder and velcro where children started from and now where they feel they are at for meeting the aim. 1-5 rating- how are you feeling?

Resources

- I can tokens
- We can box
- Cuddly toy
- Visualisation scripts

Circle time planning
Week 2
Session 2, motivation

Main aims

- Introduce the concept of motivation
- To be able to say there things that we are good
- Be able to tell you what my strengths are as a learner

	Time taken	**Activity details**
Welcome and check in	2 mins	- Quick reminder of what we did yesterday - Today's plan and main aim ' To understand how we learn best' - 1-5 rating, how are you feeling?
Warm up game	5 minutes	Rounds- Use an object such as a cuddly toy to pas round the circle. Each child is asked to complete the round when they are holding the item. Rounds such as: I feel good in school when.... I am happy to learn in school when.... I am good at .... Person next to me is good at..... I am happy to come to school when.... One of my happiest memories of school is....
Activity	10 minutes	Choose a few of the 'I can' tokens. Use the youcan toucan picture in the middle of an A3 page or board. Put the 'I can' tokens' on one side and the ask children how we can get to the other side. How can we get the 'I can' tokens? These might include: • I concentrated • I thought about what I was doing

		• I listened to my teacher • I tried hard • I practised • I kept trying Write on slips of paper those ideas that are things the child has control over. If they say because he is clever, try to encourage the children to think about what helps to make some one clever (for example: practice, listening, trying). When you have a number of ideas, write them down on stars and stick them on the opposite side of the toucan. You can if: you concentrate you listen well you try hard you practise you keep trying you believe in yourself Empty all the 'I can' tokens out of the tin. Read out some of the tokens. Ask whose token it was and ask that child what they did to help them get the token.
Warm down	5 minutes	Relaxation activity- visualisation scripts. Ask the children to either lie down or sit comfortably, close their eyes if they wish and listen carefully to the words. You can either read the scripts or make one up about a child's special place. Ask them to imagine a place that they feel safe and happy, what is around them, who is there. This should be in the heads and not really something that all children might feel comfortable to share. You can explain that some examples of a happy place may be in their bedrooms at home or in the car with a parent. Think of your own safe place and questions one could ask to elicit the context of that place. Review the learning aim of the day. Could use the ladder and velcro where children started from and now where they feel they are at for meeting the aim. 1-5 rating- how are you feeling?

		Give the children and their class teachers blank 'I can' tokens. Ask teachers or children to fill them in through the week and on the back write 'how they did it'.

Resources

- I can tokens, completed and blank
- We can box
- Picture of toucan
- Spare tokens
- Visualisation scripts

Circle time planning
Week 2
Session 3, motivation

Main aims

- To learn about the importance of planning an activity to reach a goal

	Time taken	**Activity details**
Welcome and check in	10 min	- Quick reminder of what we did yesterday - Today's plan and main aim ' To understand how we learn best' - 1-5 rating, how are you feeling?
Warm up game	5 minutes	Rounds- Warm up- Rounds- what helps me to get my work done?…. What stops me from getting my work done?
Activity	10 minutes	Sequencing- discuss the importance of making a plan. The pupils are asked to plan a trip t the zoo and are shown a related picture as a prompt. They are give a mixed series of sentence cards. Pupils are asked to sequence the sentence cards in the order in which they would need to be carried out. Pupils should be encouraged to explain their reasons for ordering. You could do this with other ideas such as making a trip to the shops, going out in the rain, getting ready for school. Ask the children to list things that need to be done and then discuss the order that you might do these in.
Warm down	5 minutes	Relaxation activity- visualisation scripts. Ask the children to either lie down or sit comfortably, close their eyes if they wish and listen carefully to the words. You can either read the scripts or make one up about a child's special place. Ask them to imagine a place that they feel safe and happy, what is around them, who is there. This should be in the heads and not really something that all

		children might feel comfortable to share. You can explain that some examples of a happy place may be in their bedrooms at home or in the car with a parent. Think of your own safe place and questions one could ask to elicit the context of that place. Review the learning aim of the day. Could use the ladder and velcro where children started from and now where they feel they are at for meeting the aim. 1-5 rating- how are you feeling?

Resources

- I can tokens
- We can box
- Cuddly toy
- Visualisation scripts

Circle time planning
Week 2
Session 4, motivation

Main aims

- To be able to plan together to meet a goal.

	Time taken	**Activity details**
Welcome and check in	10 min	- Quick reminder of what we did yesterday - Today's plan and main aim ' To understand how we learn best' - 1-5 rating, how are you feeling?
Warm up game	5 minutes	Rounds- Warm up- Rounds- what helps me to get my work done?…. What stops me from getting my work done? Rounds such as: I feel good in school when.... I am happy to learn in school when.... I am good at .... Person next to me is good at..... I am happy to come to school when.... One of my happiest memories of school is....
Activity	10 minutes	Building a newspaper tower. Ask the children to build a newspaper tower as high as they possibly can using only two of the items, choose from scissors, blue tac, cello table, glue, elastic bands etc. Now ask them to plan how they are going to achieve this together, asking questions such as: What the overall goal? What steps do we need to take? Who is going to do what? How are we going to work together? Shall we write a plan down? Could use pictures on big piece of A3 paper so that everyone can be involved in recording the plan. If the tower is over x cm's high, there could be a reward?
Warm down	5 minutes	Relaxation activity- visualisation scripts. Ask the children

		to either lie down or sit comfortably, close their eyes if they wish and listen carefully to the words. You can either read the scripts or make one up about a child's special place. Ask them to imagine a place that they feel safe and happy, what is around them, who is there. This should be in the heads and not really something that all children might feel comfortable to share. You can explain that some examples of a happy place may be in their bedrooms at home or in the car with a parent. Think of your own safe place and questions one could ask to elicit the context of that place. Review the learning aim of the day. Could use the ladder and velcro where children started from and now where they feel they are at for meeting the aim. 1-5 rating- how are you feeling?

Resources

- I can tokens
- We can box
- Cuddly toy
- Visualisation scripts

Circle time planning
Week 3
Session 1, developing empathy

Main aims

- To recognise that everyone has different intensity's of the same feeling

	Time taken	**Activity details**
Welcome and check in	10 min	- Quick reminder of what we did last week - Looked at things we are good at and how we are motivated. We also made a tower and planned how we were going to do this as a team. - Today's plan and main aim 'to understand that we all have different feelings about the same objects' - Could use ladder to see if we have met today's aim at the end. - 1-5 rating, how are you feeling?
Warm up game	5 minutes	This week is about developing empathy, and this begins by paying attention to subtle differences in facial expressions and non verbal language. Warm up- ask one child to leave the room for 2 minutes while another child in the group wither changes places and takes off jumper etc. The child coming in has to guess what has changed.
Activity	10 minutes	Ask the children to write down some of the things that - Make them happy - Make them sad - Make them angry - To save time and enhance concentration, this could be done in a previous session. Put the slips of paper in three different bags, a happy bag, a sad bag and an angry bag. Take these out one at a time and ask the children to stand on the number line that best shows how they feel about that item, do this for happy, sad and angry. 1 can be really happy and 10 can be not very happy at all etc.
Warm down	5 minutes	Use relaxation activities to choose sand model strategies to children, ie, relaxing like a cat.

Resources

- Laminated number line
- Small slips of paper
- 3 safe bags such as paper gift bags

Circle time planning
Week 4
Session 2, developing empathy

Main aims

- To be able to tell the difference between friendly and unfriendly statements and think about how we can be more friendly using acts of kindness charts.

	Time taken	**Activity details**
Welcome and check in	10 min	- Quick reminder of what we did yesterday - Could use ladder to see if we have met today's aim at the end. - 1-5 rating, how are you feeling?
Warm up game	5 minutes	This week is about developing empathy, and this begins by paying attention to subtle differences in facial expressions and non verbal language. Ask children to work in pairs, one child has to pull a face and the other has to guess which feeling they are demonstrating. You could use feelings cards for children to choose and then pull the related face. Could use mirror too. Or Play the game where one child goes out of the room and a detail changes in the group, the child then has to guess the detail that changed.
Activity	10 minutes	Have a look at the worksheet titled friendly and unfriendly statements, could use big flip chart paper to stick the statements in the correct column. Discuss as a group. Ask the children when can they us acts of kindness or be friendly statements. Ask them to record on a acts of kindness log friendly things they do next week.
Warm down	5 minutes	Use relaxation activities to choose sand model strategies to children, ie, relaxing like a cat.

Resources

- Acts of kindness log

- Friendly and unfriendly statements

Circle time planning
Week 3
Session 3, developing empathy

Main aims

- To be able to recognise feelings from non verbal cues

	Time taken	**Activity details**
Welcome and check in	10 min	- Quick reminder of what we did yesterday - Could use ladder to see if we have met today's aim at the end. - 1-5 rating, how are you feeling?
Warm up game	5 minutes	This week is about developing empathy, and this begins by paying attention to subtle differences in facial expressions and non verbal language. Ask children to work in pairs again and guess each others feeling from their facial expression.
Activity	10 minutes	Look through newspapers and magazines to look specifically at how we can tell someone's mood- use speaking without words worksheet and complete as a class.
Warm down	5 minutes	Use relaxation activities to choose sand model strategies to children, ie, relaxing like a cat.

Resources

- Speaking without words sheet
- Newspapers and magazines

Circle time planning
Week 3
Session 4, developing empathy

Main aims

- To be able to tell the difference between friendly and unfriendly statements and think about how we can be more friendly using acts of kindness charts.

	Time taken	Activity details
Welcome and check in	10 min	- Quick reminder of what we did yesterday - Could use ladder to see if we have met today's aim at the end. - 1-5 rating, how are you feeling?
Warm up game	5 minutes	This week is about developing empathy, and this begins by paying attention to subtle differences in facial expressions and non verbal language. Ask children to work in pairs, one child has to pull a face and the other has to guess which feeling they are demonstrating. You could use feelings cards for children to choose and then pull the related face. Could use mirror too. Or Play the game where one child goes out of the room and a detail changes in the group, the child then has to guess the detail that changed.
Activity	10 minutes	Have a look at the worksheet titled friendly and unfriendly statements, could use big flip chart paper to stick the statements in the correct column. Discuss as a group. Ask the children when can they us acts of kindness or be friendly statements. Ask them to record on a acts of kindness log friendly things they do next week.
Warm down	5 minutes	Use relaxation activities to choose sand model strategies to children, ie, relaxing like a cat.

Resources

- Acts of kindness log
- Friendly and unfriendly statements

Circle time planning
Week 4
Session 1, social skills

Main aims

- To recognise the appropriate response in a range of situations.

	Time taken	**Activity details**
Welcome and check in	10 min	- Quick reminder of what we did last week - Looked at empathy and how we could empathise more with others. - Today's plan and main aim 'to recognise the right response in a difficult situation'. - Could use ladder to see if we have met today's aim at the end. - 1-5 rating, how are you feeling?
Warm up game	5 minutes	Feelings charades- In pairs or as a group, choose one of the feelings cards and then mime the action, see if your partner can guess which feeling it is just from your actions. Afterwards you would ask the children to identify when they may have felt that way and what they did in response to that feeling.
Activity	10 minutes	Sort and match game- see worksheet 16. As a group match the situations with the appropriate response. Also keep some blank cards and ask the group to think of their own difficult situations and possible suitable responses.
Warm down	5 minutes	Use relaxation activities to choose sand model strategies to children, ie, relaxing like a cat.

Resources

- Worksheet 16
- Feelings cards

Circle time planning
Week 4
Session 2, social skills

Main aims

- To recognise your own success.

	Time taken	Activity details
Welcome and check in	10 min	- Today's plan and main aim 'to recognise things you are good at' - Could use ladder to see if we have met today's aim at the end. - 1-5 rating, how are you feeling?
Warm up game	5 minutes	Feelings charades- In pairs or as a group, choose one of the feelings cards and then mime the action, see if your partner can guess which feeling it is just from your actions. Afterwards you would ask the children to identify when they may have felt that way and what they did in response to that feeling.
Activity	10 minutes	Discuss as a group that sometimes recognising what we do well makes us feel good and recognising what others do well also makes us feel good. Use worksheet number 6 to complete together, children can either write or draw their successes. You may wish to ask the group for one idea for each other. You could also complete one of the points beforehand so the pupil can see that the teacher has also recognised something they are good at or have done well.
Warm down	5 minutes	Use relaxation activities to choose sand model strategies to children, ie, relaxing like a cat.

Resources

- Celebrate your success worksheets
- Feelings cards

Circle time planning
Week 4
Session 3, social skills

Main aims

- To recognise that you are in control of your own actions and have a number of options that you could carry out in a difficult situation.

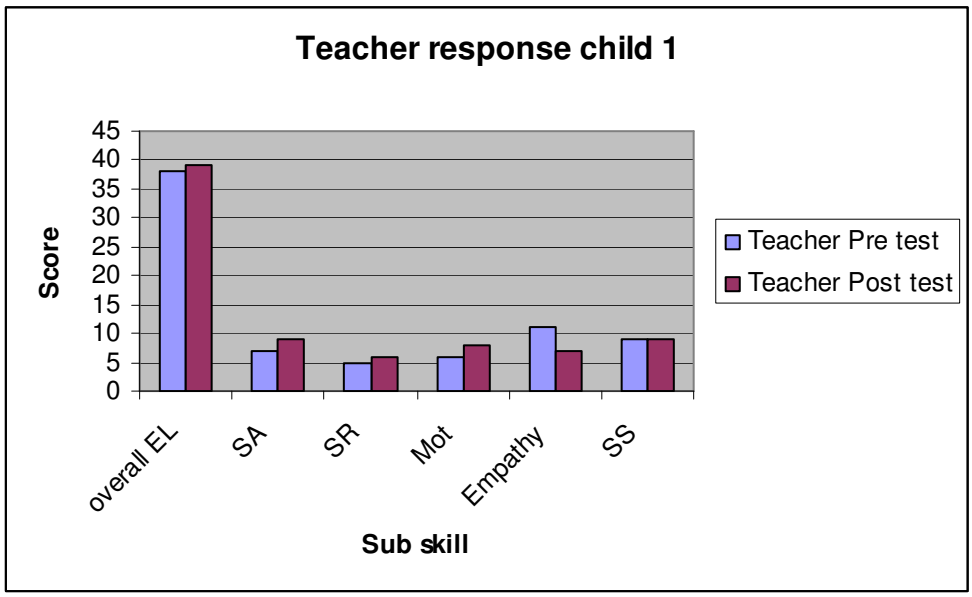
	Time taken	Activity details
Welcome and check in	10 min	- Today's plan and main aim 'to recognise that you can choose the best way to act in a difficult situation' - Could use ladder to see if we have met today's aim at the end. - 1-5 rating, how are you feeling?
Warm up game	5 minutes	Feelings charades- In pairs or as a group, choose one of the feelings cards and then mime the action, see if your partner can guess which feeling it is just from your actions. Afterwards you would ask the children to identify when they may have felt that way and what they did in response to that feeling.
Activity	10 minutes	The 'what can I do?' game. As a group discuss the situations from the worksheet and the possible actions that one might carry out. Keep some blank cards and ask the children to think of their own situations and responses. You could also use role play to act out some of these situations so the children have a go at modelling and rehearsing appropriate skills that they can use in similar situations.
Warm down	5 minutes	Use relaxation activities to choose sand model strategies to children, ie, relaxing like a cat. Some reflections around circle time? Have you enjoyed it? What have you learnt? Can you tell me about your favourite and least favourite session and why? Do you do this in class? Would you like to? What have you learnt here that you could use in class or school?

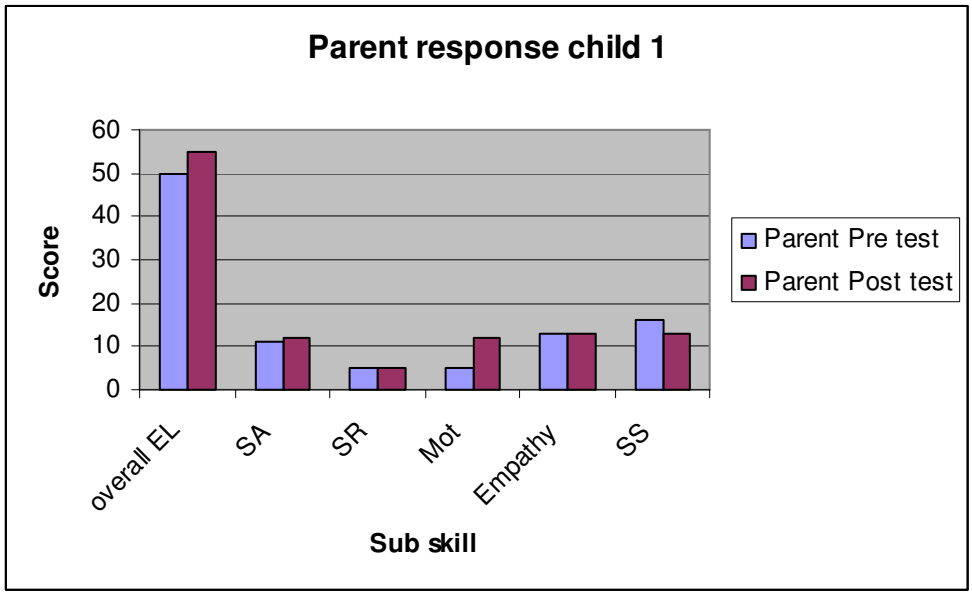
Resources

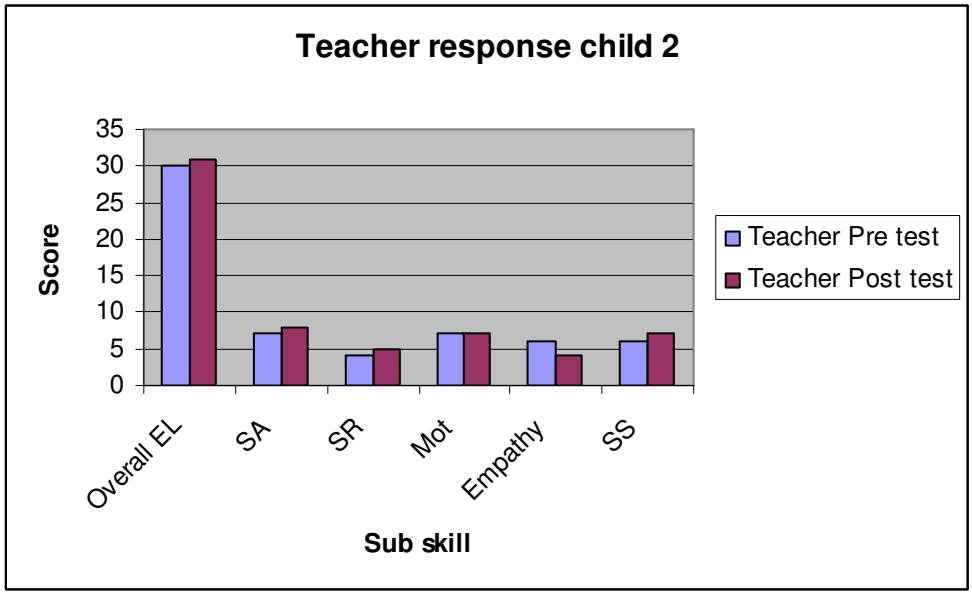
- The 'what can I do?' game worksheet.

- Feelings cards

Appendix 5: Results from the ELAI questionnaires for parents and teachers







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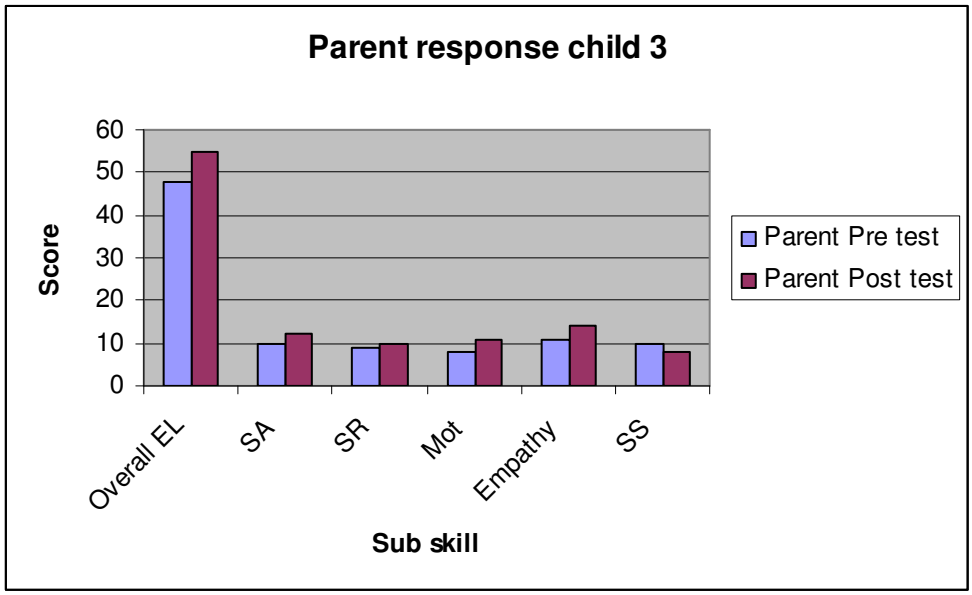

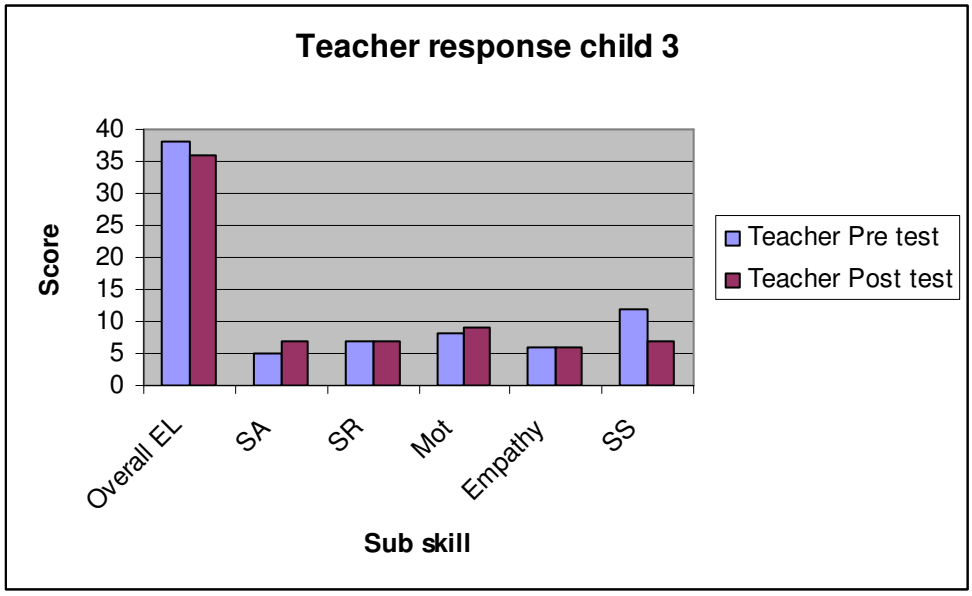
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Teacher Pre test
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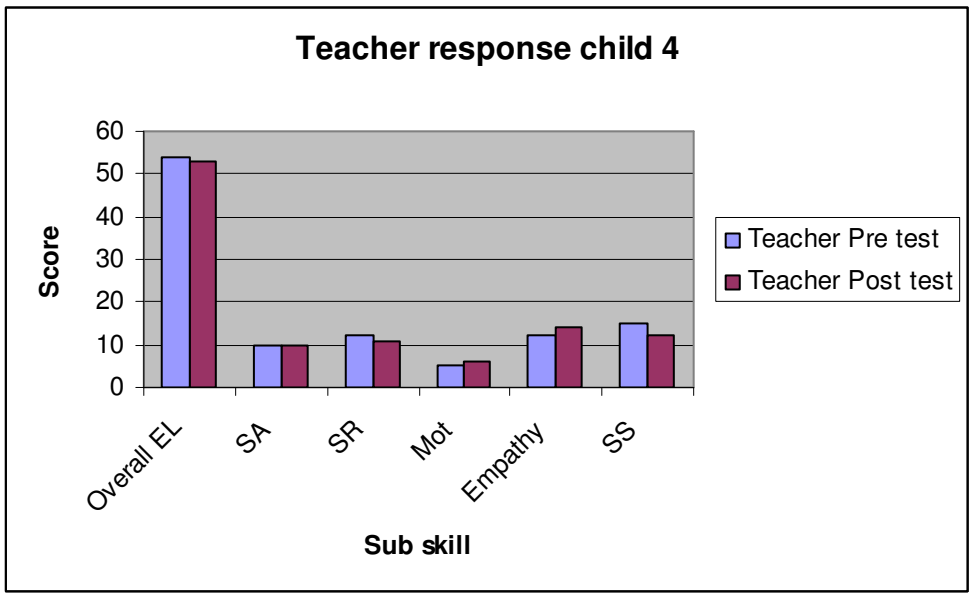
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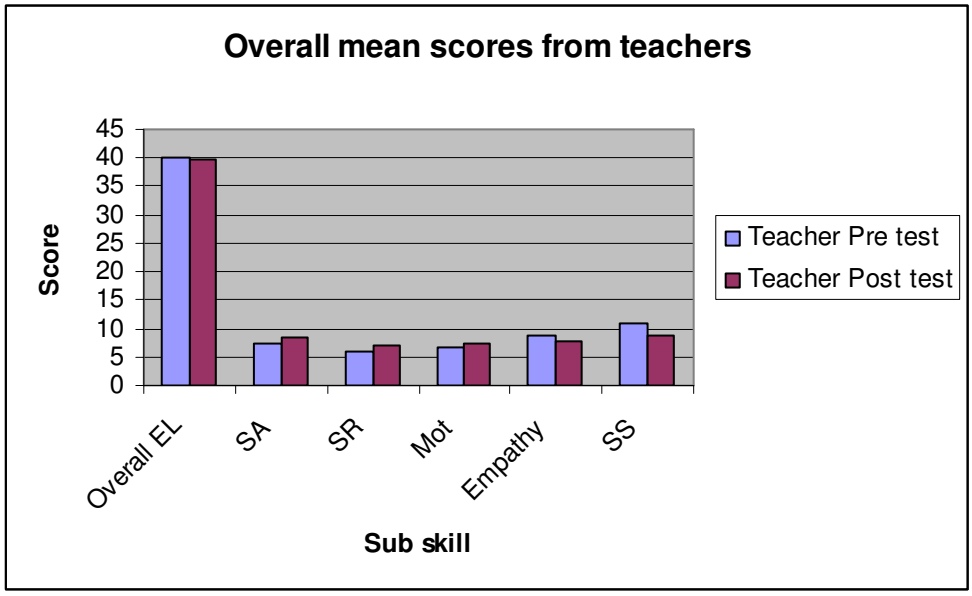
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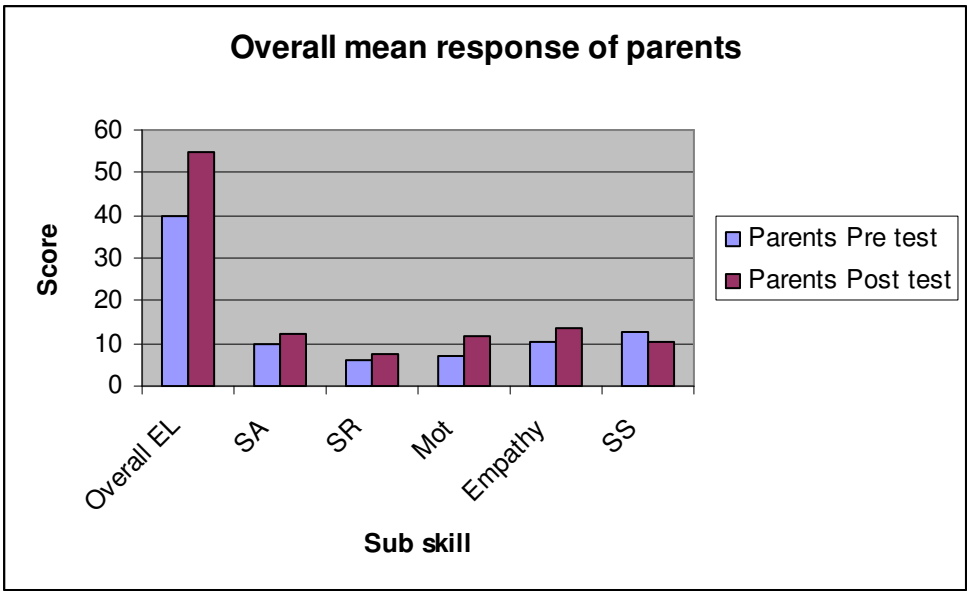
Overall mean response of parents
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Parents Pre test
Parents Post test

Appendix 6: A description of key themes from interviews with the facilitator of the Rainbow Room and class teachers.

Effectiveness of the programme

The facilitator felt that the use of the emotional literacy programme as delivered through circle time had been effective to a degree, she felt that some of the sessions were too long for the children and so took some of the ideas and used them for a shorter length of time. The activities therefore needed to be shorter and use fewer resources as she did not always have time to prepare the resources.

Generalisation of skills

The facilitator felt that one child in particular had benefited from the group as he now seemed slightly calmer and he could use some of the strategies discussed in circle time when feeling angry or frustrated. He can also explain his feelings better now, especially when he is beginning to feel angry. However, whilst the facilitator could see a difference in the pupils within the Rainbow Room, she felt that there was no bridging to allow the children to generalise their developing skills back into the classroom. Teachers were not made aware of the strategies and content of the sessions and so children were not reminded of particular strategies taught if they became angry in class, rather class teachers would revert to previous strategies such as time out of the classroom. The facilitator felt that there was also a lack of ownership of such strategies, that is that class teachers did not feel it was their role to enquire or use the strategies that had been explored in circle time.

When asked about possible barriers to the effectiveness of the programme the facilitator felt that a lack of responsibility from staff in the school led to a lack of opportunity to generalise the skills learnt during circle time sessions within the rainbow room. She also reported that sometimes the logistics of the school impact the group, that is if there is a trip that she needs to go on then the rainbow room does not run which leads to a lack of consistently for the children. She felt that really the room needs to be supported by two adults.

Confidence

On a scale of 1-10, 1 being not very confident at all and 10 being really confident, the facilitator rated her confidence to run circle times before and after the intervention at a 7 and 9, respectively. She reported that her confidence had increased due to having pre-planned resources that she could dip in and out of.

ELAI measure

The facilitator was absent when the first assessment measure were completed. On reflection, she felt that she would have liked to have seen this process in order to gain a better understanding of what the numbers corresponding to overall emotional literacy meant. She reported that she does use her own rating scales at the beginning and end of each session as a way of evaluating each session.

Manageability

The facilitator felt that she would have benefited from more time to go over the plans and would benefit from having a second adult in the room. This would also allow the adults to model appropriate social and emotional skills to the children in the group. The facilitator reported that she felt confident to continue using circle time as she could continue to build on the resource developed by the researcher.

Labelling

The purpose of the Rainbow Room changed during the project, originally the four boys spent four afternoons per week in the room whereas now there are a number of groups that rotate their time in the Rainbow Room. Two of the boys still attend the group and circle time for four afternoons per week whereas the other two attend the group for just three afternoons per week. The facilitator felt that this had led to a positive change in the attitudes of other children within the school. Previously there were comments such as 'you can't go in there unless you have ADHD' whereas now the room is seen as a place where small group work and circle times happens in the afternoon. Children now seem to be working together better, recognising differences between each other and working with them rather than against them.

Interview with class teachers

One of the class teachers felt that is was too early to see a real difference in the behaviour of one pupil. He reported that this pupil is only in his class for a very short period each day. He spends time with a mentor in the morning and rainbow room in the afternoon. The teacher is aware that circle time sessions have been happening in the rainbow room but did not know about any specific strategies around self regulation for example that the children had learnt.

Another class teacher felt that there had been some improvement in one pupil's behaviour, again she did not know about strategies that had been taught in the Rainbow Room but would be keen to see an overall plan.

The third teacher interviewed felt that the pupil in her class was making good progress in the group and now seems to be able to work with others more effectively, for example he recently said 'its much better if we to it as a team.' She was aware that the circle time sessions had been focusing on team work that week but was not aware of specific strategies being taught.

CHAPTER 3- PROFESSIONAL PRACTICE REPORT 2

3. 1 Title

An investigation into how one local authority seeks to raise the achievement of Looked After Children.

3. 2 Abstract

An Educational Psychologist (EP) working for the Looked After Children's Team LAC's (LAC) Team, a Designated Teacher (DT) working within a local school and a Project Coordinator (PC) from a local authority were individually interviewed by a Trainee Educational Psychologist (TEP). The aim of the interviews was to explore each participant's perceptions of the achievement of Looked After Children (LAC) within the local authority. A thematic analysis was conducted and demonstrated six key themes; attendance, stability of placements, training, the role of the EP, projects, and care homes. Interviewees felt that the instability of care placements was still an issue for LAC and that overall the outcomes for those in foster care were better than for those who attended children's homes. It is recommended that the government need to ensure the stability of care placements at both a national and local level and do their utmost to ensure that children are placed with foster carers rather than in care homes. There are also implications for the type of work that EPs engage in and the role that EPs might take during annual review and transition meetings. It was beyond the scope of this research to explore the views of LAC. However this would be an interesting extension of the project.

3.3 Literature review

The term Looked After Children (LAC) was introduced in the 1989 Children Act and describes LAC as those children and young people who are subject to care orders and those who are provided with accommodation by the local authority (Children's Act. 1989; S.22. 1a). The Children Act, 1989 and subsequently Section 52 of the Children Act, 2004 place a duty on local authorities to promote the educational achievement of looked after children (Children Act, 1989; Children Act, 2004). Local authorities in their role as 'corporate parents' should therefore demonstrate the strongest commitment to helping LAC to achieve the highest educational standards they can (DfES, 2005)

There are essentially two routes via which a child or young person can enter the care system and become a LAC. This may be through a voluntary agreement with the child's parents in accordance with Section 20 of the Children Act 1989 which may happen when parents feel unable to cope and meet their child's needs. Under Section 20 the child's parents retain full parental responsibility for the child and all decisions must be made in partnership with parents. The second route in which a child may come into care is through a legal or court order such as a Police Protection Order, an Emergency Protection order or an Interim Care Order (Children Act, 1989).

3.3.1 The national picture

In September 2008 there were 43,700 children who had been looked after continuously for at least twelve months by English Local Authorities (DCSF, 2009). 33,000 of these children were of school age and of these 28% had a Statement of Special Educational Needs. 12% had missed at least 25 days of school and 1% had received a permanent exclusion. The vast majority (80%) of children enter care because of abuse, neglect, family hardships or other factors relating to their families (DCSF, 2009; SEU, 2003). Around two-thirds of LAC live in foster care and more than one in ten children, usually in their teens, live in a children's home (DCSF, 2009).

Whilst the educational attainment of LAC is lower than those who are not in care, it is important to note that there are significant variations in the educational attainment of the care population. There are numerous factors which may impact upon the educational attainment of children in care including the reasons they initially came into care; the length of time in care; the type of placement they are in and the stability of those placements and their gender. LAC therefore form a heterogeneous group of the population and whilst many of their needs will be similar it is important not to lose sight of the fact that each child and the story they tell is individual and therefore not all children will experience negative consequences of being in care.

In 2008, just 14% of children looked after continuously for at least 12 months obtained at least 5 GCSE's or GNVQ at grades A*-C compared to 65% of all school children. Table 1

highlights the comparison in performance at key stages 1, 2 and 3 for English Maths and Science between LAC and all children from 2006- 2008.

	LAC (%)			**All children (%)**		
	2006	2007	2008	2006	2007	2008
Key stage 1 (At least a level 2)						
Reading	57	55	57	84	84	84
Writing	52	51	50	81	80	80
Mathematics	65	64	62	90	90	90
Key Stage 2 (At least a level 4)						
English	43	46	46	79	80	81
Mathematics	41	43	44	76	77	79
Science	57	59	60	87	88	88
Key Stage 3 (At least a level 5)						
English	28	29	30	73	74	73
Maths	33	31	33	77	76	77
Science	29	29	29	72	73	71

Table 1: Performance of children who had been looked after continuously for at least twelve months in key stages 1-2 compared with all children between 2006 and 2008 (Statistical first release, DfCSF, 2008).

The statistics from the DCSF (2008) demonstrate a clear trend in the educational outcomes for LAC. Throughout national key stages 1-3, LAC achieve less than all children. Moreover, the gap appears to increase as children get older (See Figure 1).

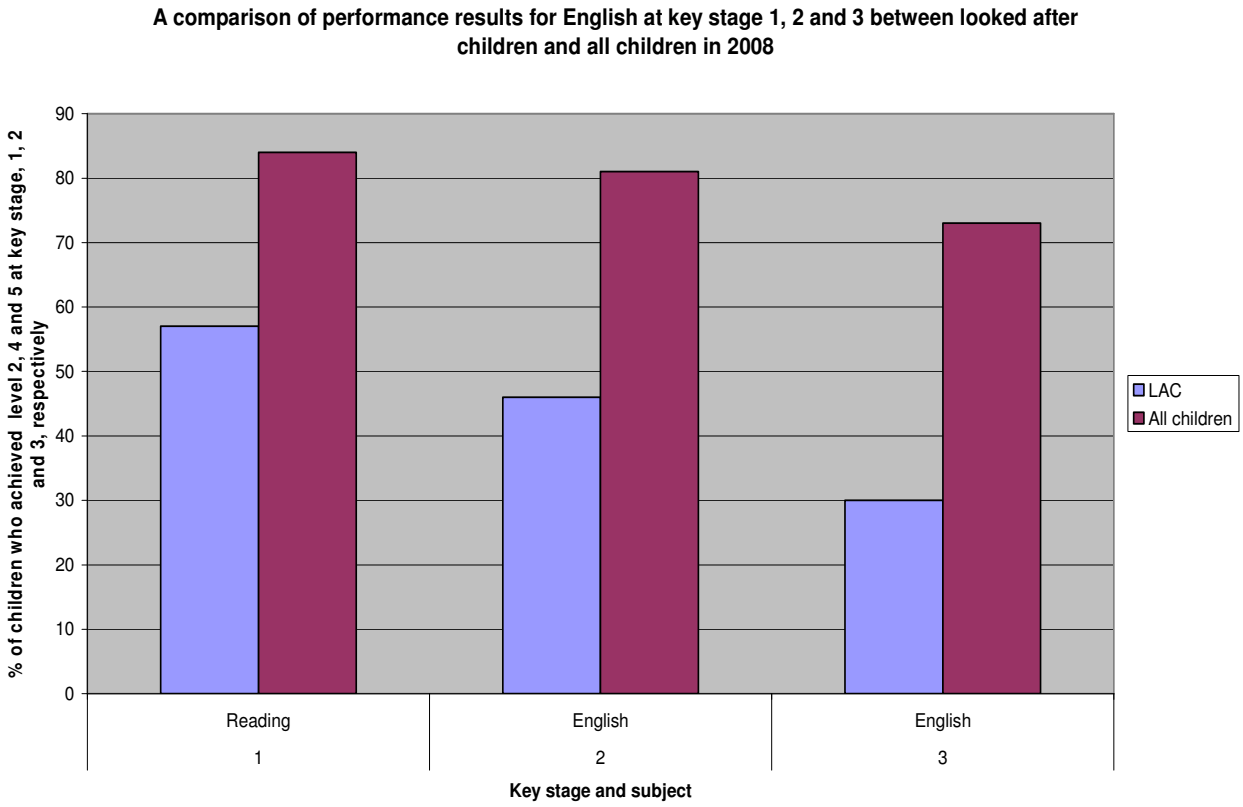

Figure 1: A comparison of performance for reading and English at key stages 1, 2 and 3 between LAC and all children in 2008 as taken from Statistical First Release (DCSF, 2008).

The Social Exclusion Unit (2003) argue that many children in care enjoy going to school and almost all think it is important but a large number have had poor experiences in education, for example, six in ten have reported being bullied and children in care are thirteen times more likely to be permanently excluded than their peers. One of the key factors identified in this report was the lack of stability for children in care. Children in care are likely to have experienced an unstable upbringing before they even enter the care system and at a time

where they need and would benefit from consistency and stability they are actually faced with further change, insecurity and doubt which may therefore be one factor that contributes to poorer outcomes for children in care.

There are a number of factors that may influence the outcomes of children in care that operate at three different levels:

- Pre care factors
- The care system
- The schooling system

(DCSF, 2009)

3.3.2 Pre care factors

Berridge (2007) believes that parental maltreatment is strongly linked with educational failure. Children who go into care have often experienced maltreatment which could be a contributing factor to poor educational outcomes. Berridge (2007) states that many reports and enquiries have highlighted cases where social services have failed vulnerable children as the care system in which they were placed was flawed. Whilst the care system may be flawed in many respects, Rutter (1999) argues that the social risk factors associated with family breakdown and entry into care themselves are closely linked with educational failure and thus we need to consider factors that may have impacted the individual and their educational attainment before they even entered the care system as well as addressing the care system itself. An example of a pre care factor that may impact on outcomes for LAC is the

relationship and bonding that the child or young person experienced with their biological parents.

For many years, attachment theory has provided a well documented psychological theory that bridges a link between parental maltreatment and poor educational and social outcomes experienced by children that Berridge (2007) emphasises. Attachment theory was developed by Bowlby (1969) and has been extended by researchers such as Ainsworth and Bell (1970) and Ainsworth et al (1978). On a practical level, the use of nurture groups within schools is underpinned by attachment theory (Bennathon & Boxhall, 1998, 2002: Boxhall, 2002).

An 'attachment style' describes our pattern of relating to 'significant others', that is the important people in our lives (Bomber, 2007). Such attachment styles or patterns develop and evolve over our early years through experiences and interactions with our carers or parents. Affective attunement, defined as the intersubjective sharing of affect, is central to the development of a secure attachment during the first year of life (Stern, 1985). Approximately 55-65% of the population will develop secure attachments with their parents or caregivers (Howe, 1999). Figure 2 shows a number of characteristics which a securely attached child may demonstrate.

- Confident to go out and explore different relationships and the wider world
- Have the necessary confidence to make the most of learning opportunities
- Are able to take risks required by the learning process and will usually reach their academic potential
- Are able to form meaningful relationships with others
- Experience relationships as genuine
- Have a high level of self esteem and a robust resilience to deal with any difficulties they may experience at school.
- Are able to work independently and ask for help when appropriate.

Taken from Bomber, 2007.

Figure 2. Characteristics shown by securely attached children, taken from Bomber, 2007.

Insecure attachment styles are more likely to be dominant in those children who have experienced trauma and loss. This may include emotional abuse, sexual abuse, neglect, physical abuse or domestic violence. Children who have experienced trauma and loss learn very early on that they are worthless and their needs are unimportant (Hughes, 2006). Children then learn to adapt to such an environment in order to survive and ensure that their primary needs, i.e. food, drink and security are met. Some children may appear withdrawn and attempt to meet their needs by themselves, whereas others may scream, shout and rage to ensure they get something even if it's just a scrap of attention, positive or negative (Bomber, 2007). Such learned responses can become very entrenched and are used to relate to other people both within and out of the family context (Hughes, 1997, Gerhardt, 2004).

Ainsworth et al (1978) describes three main insecure attachment styles; avoidant resistant-ambivalent and disorganised- disoriented.

Avoidant: Does not cry on separation, attending to toys or environment throughout procedure. Actively avoids and ignores parent on reunion, moving away, turning away or leaning away when picked up. Unemotional; expressions of anger are absent.

Resistant- Ambivalent: Preoccupied with parent throughout procedure, may seem actively angry, alternatively seeking and resisting parent, or may be passive. Fails to return to settle or return to exploration on reunion and continues to focus on parent and cry.

Disorganised- disoriented: Disorganised or disorientated behaviours displayed in parents presence; for example, may freeze with a trance like expression, hands in air, rise then fall prone at parents entrance or cling while leaning away.

Taken from Slater (2007).

Figure 3. Styles of attachment and associated behaviours from Ainsworth et al (1978)

Bomber (2007) describes a number of characteristics which a child who is insecurely attached may demonstrate in relationships with others, the learning environment and within their sense of self.

In relationships:

- Difficulties trusting others
- Difficulties making and keeping friends
- Don't seem to understand others feelings
- Social communication difficulties
- Over familiar
- Unable to trust and follow an adults lead in class
- Heightened sense of justice- over sensitive to potential 'disrespect'
- Lying
- Difficulties with eye contact and touch
- Don't seem to know why they did what they did
- Seem quite superficial and difficult to connect with
- Don't seem to have a sense of remorse
- Clingy
- Seem expressionless
- Unable to smile, laugh or have much fun

In the learning environment:

- Unable to cope with unexpected/unplanned change to their routine
- Organisational difficulties
- Seem to 'tune out' of what is going on
- Unable to concentrate
- Unable to progress in their learning
- Speech and language difficulties
- Have fine and gross motor skill difficulties
- Don't respond consistently to the use of rewards and sanctions in class.

Sense of self:

- Poor sense of self and impoverished view of the future
- Do not seem to know the difference between right and wrong
- Jumpy and on edge- constantly checking out their environment
- Stare into the distance as if in a world of their own
- Fidgety
- Become over excited very easily
- Show over reactive responses to difficulties or conflicts that can result in aggressive behaviours
- Memory difficulties
- Display inappropriate sexualised behaviours
- Verbally abusive
- Lack of self awareness
- Seem unable to describe how they are feeling.

Figure 4. A summary of how children can express the effects of insecure attachments (Bomber, 2007, p.2)..

Schore (2002) succinctly integrates research findings on attachment theory, affective neuroscience, developmental stress research and infant psychiatry and argues that traumatic attachments in the first two years of an infant's life have a negative impact upon the early maturing right brain. He argues that traumatic attachments lead to structural and enduring changes in the development of the brain which have long lasting effects on behavioural responses and stress coping mechanisms during both childhood and adulthood. Cumulative and chronic unpredictable stress during the infants first two years of life are thought to have the most consequential impact on the developing brain (McEwen, 2000).

From a neurological perspective then, it seems that there is a possible link between attachment, brain development and behaviour. Prolonged, unpredictable stress as experienced by some LAC before they enter the care system may have a significant impact on their behaviour and educational attainment. Such behaviours may include poor concentration in the classroom, impulsivity and an inability to deal with unexpected changes as previously detailed by Bomber (2007). From a neurological perspective, it seems that a child who has experienced insecure attachments is almost predetermined to experience a negative developmental trajectory although this is not the case at all and it is important to consider the interactions between biological and environmental factors such as care placements and schooling.

Other factors that may present risk to the quality of attachment of the child to their parent may include pre birth stress such as domestic violence to the mother, alcohol or drug taking during pregnancy, parental illness before or after birth, poverty or mental health difficulties in the caregiver (Bomber, 2007). These factors highlight that whilst there is a possible link between

the development of the brain and behaviour, there are a number of environmental factors that can impact upon the development of the brain before and after birth and it is therefore a combination of environmental and neurological factors that can lead to the development of insecure attachments.

3.3.3 The care system

Children who go into the care system have often experienced unstable and inconsistent parenting and life experiences. Coming into care therefore should be the beginning of a more stable environment that promotes opportunities for the child to develop and thrive. However, in reality placements often breakdown and lead to a number of moves between foster homes and residential placements (Department for Education and Employment & Department of Health 2000). The placements may not always be geographically close which can mean that children have to move schools in addition to homes and consequently also experience inconsistent contact with both siblings and their biological parents. A Better Education for Children in Care (SEU, 2003) documented that one in seven LAC had three or more care placements in 2001/2002 and over one third of young people consulted had changed schools at least twice as a result of change in care placements (DCSF, 2009).

A move of school for a child in a settled family with supportive parents can be stressful, involving a loss of friends, familiar teachers and surroundings. For a child in public care, who may have suffered abuse or harm in his or her own family, a change of school can have a more marked impact on their emotional wellbeing behaviour and educational attainment. For the school, teachers may not have appropriate information about a child's circumstances,

reasons for coming into care, their educational history or overall needs as often a change of school can occur quite suddenly (DfEE, 2000).

Instability in both home and school placements is almost universally cited as contributing to poor educational outcomes for LAC (Jackson, 1998; Francis, 2000; Jackson & Thomas, 2001; Stein, 1994) and the students least likely to be entered for their GSCE's are those who have experienced the most changes in their school placements (Fletcher- Campbell & Archer, 2003). It seems that moves at critical times such as just before assessment points are likely to influence measured achievement markedly. Data presented in Care Matters (DfES, 2006) shows a negative correlation between the number of placement moves in year 10 and 11 and academic achievement. Reasons for this may include logistical factors such as the organisation and completion of coursework. Coursework may be lost if the young person has moved to an establishment that does not offer the same curriculum (O'Sullivan & Westerman, 2007). LAC may also be out of school temporarily while placements are being rearranged and therefore are missing out on opportunities to access educational provision (Goddard, 2000).

From a psychological perspective, if LAC are moving placements more than three times in one year then they are unlikely to feel a sense of belonging and thus according to Maslow's hierarchy of need are unable to reach their educational potential and self actualisation (Maslow, 1943). In addition, for LAC, placement moves are often not planned and follow the breakdown of their relationships with carers (O'Sullivan & Westerman, 2007) which may further reinforce feelings of worthlessness and rejection generated from previous insecure attachments. A 'life punctuated with insecurity' (O'Sullivan & Westerman, 2007, p17) and a

lack of continuity in care providers and teachers means that young people in public care cannot rely upon familiar adults who they trust to advocate for their needs (DEE, 2000).

Improved educational attainment has been linked to planned and long term foster care placements. Jackson and Ajayi (2007) found that children in residential homes reported that staff showed little interest in their school experience beyond occasional enquiries about whether they had done their homework. In contrast, those who received long term foster placements spoke very warmly of their foster families and the support and encouragement that they received from them. The majority of participants attributed their educational recovery to increases in their own motivation and the remedial efforts of their foster carers giving them the feeling that there was somebody who really cared about what happened to them at school and wanted them to succeed. Foster care is therefore an integral part of the education system that can raise the aspirations and attainment of LAC and plays a major role in enabling more children to access higher education (Jackson & Ajayi, 2007).

3.3.4 The School System

Research has consistently demonstrated that LAC are more likely to experience a relatively low level of educational attainment (DCSF, 2009). Unidentified or unsupported learning difficulties and insufficient training for teachers are additional inhibiting factors for the achievement of LAC:

> ‘Schools and teachers are in a prime position to do something, one student at a time, to change the educational trajectories of looked after/ adopted children. Since

> primary school teachers spend six hours per day, five days a week with the same children, they are invaluable mentors for those whose lives have been unreliable and bleak…A first step is to read and learn more about children in the care system and to acquire at least a basic understanding of the issues unique to them' (Comfort, 2007, p32).

Goddard (2000) also highlights high rates of exclusion and non attendance as two crucial factors that impact upon the attainment of LAC. It is estimated that LAC are ten times more likely to be excluded than those outside of the care system (SEU, 1998) and are therefore more likely to spend extended periods of time out of school. The relationship between the success of a school placement and a care placement is an intimate one in that a breakdown in one setting is likely to impact negatively on the other setting.

Figure 5 summarises the key barriers identified in research to the educational success of LAC.

3.3.5 What are government already doing?

There are a wide range of developments, documentation and guidance about supporting the needs of LAC, some of the key legislation is detailed below.

Under Section 22 (3a) of the Children Act 1989 (as amended by section 52 of the Children Act 2004) Local Authorities, in carrying out their duty to safeguard and promote the welfare of LAC, must give particular attention to the educational implications of any decision about the welfare of those children. In practical terms, this requires the inclusion of children's

- Poor mechanisms to identify LAC (DCSF, 2009; DfEE, DoH, 2000);
- A need to develop a more secure knowledge base for the staff working with LAC (DCSF, 2009);
- Poor attendance and high rates of exclusion (Goddard, 2000; DfEE, DoH, 2000);
- Lack of stability within educational placements (Goddard, 2000);
- Making and sustaining relationships with peers can be particularly difficult due to lack of continuity in care and schooling (DfEE, DoH, 2000);
- Social services and LEAs, individual schools, carers, social workers and teachers are unclear about their respective roles and responsibilities (DfEE, DoH, 2000);
- Schools and carers display lower expectations of young people in public care which can contribute to underachievement and failure (DfEE, DoH, 2000);
- The special educational needs of some young people in care are not identified or addressed (DfEE, DoH, 2000).

Figure 5. A summary of barriers identified in recent research to the educational success of LAC.

educational needs and how to meet such needs to be detailed in individual care plans (Goddard, 2000).

Corporate parenting emphasises the collective responsibility of Local Authorities to achieve good parenting. The 1989 Children Act and the UN Convention on the Rights of the Child also require those with responsibility for children to ascertain their wishes and feelings (Children act, 1989; United Nations Convention 1989).

The Social Exclusion Report (1998) recommended that targets should be set for the educational achievement of LAC. This approach was followed up by the 'Quality Protects' initiative which required Local Authorities to meet specific targets including reducing the number of LAC who had three or more placements per year and increasing the number of young people leaving care with a GCSE or GNVQ qualification.

More recently the DCSF (2009) have published a strategy to support the needs or LAC and ensure that every LAC has the opportunity to do as well as their peers.

The strategy includes the need for:

- Local Authorities to have a Virtual School Head (VSH) who should make sure that there is a systematic, disciplined tracking of the education of every individual child in care, ensure that every school has the information they need, make sure there is a Personal Education Plan (PEP) and one to one support available for each LAC, promote a focus on the educational attainment across the authority and work to improve behaviour and attendance. It is imperative for Local Authorities to have somebody at senior level who is accountable for the attainment of LAC overall.
- A designated teacher within school who will be responsible for arranging a PEP with each LAC in their school and support the delivery of individual programmes such as one to one tuition for LAC
- Local Authorities to provide stable placements and schooling.

DCSF (2009)

Figure 6. A summary of the DCSF strategy for LAC.

More specifically to the role of the EP, recent guidance from the DfES (2005) and the British Psychological Society (2006) suggests that Educational Psychology Services should have a designated post for LAC, which should be filled by a senior member of staff with at least three years experience as an EP, knowledge of the circumstances which disrupt children's lives and skills in multi agency working. The EP should be working with schools to help them understand how they can promote resilience amongst LAC (Gilligan, 2001) and ensure that schools have an understanding of the issues and resources available to support LAC. This can be achieved through a number of ways of working;

- Providing training courses for school staff;
- Including school staff in multi agency working;
- Using consultations about the child to promote insights and develop support systems;
- Promoting residential workers/foster carers/adoptive parents as sources of information and strategies;
- Preparing hand outs with resources for teachers;
- Advising schools with regard to systems which can detect difficulties and deliver effective support.

EPs should also provide a specialist service which is prompt and flexible to contribute to promoting continuity or provision and appropriate educational opportunities for the child and therefore could play a crucial role in securing a stable placement for a child at an annual review or emergency review meeting. EPs also have a role to play in assessment and intervention for LAC, which may include gathering information about the child's early history, views of other professionals involved and information about their current educational

and care placements. EPs therefore have a role to play within individual casework for LAC as well as promoting issues such as attendance, exclusion rates, stability of placements and promoting the overall wellbeing of LAC within the school system. Despite high ambitions and a shared commitment for change, the white paper *Care Matters: Time for Change*, published in June 2007 states that there is still a significant gap between the quality of the lives of LAC compared to all other children.

The following section details a critical review of how such guidance from government has been implemented to support the needs of LAC by one local authority.

3.4 Methodology

A literature review which aimed to explore recent research findings, underlying psychological theories and government legislation around LAC was initially completed. The findings from this review were then used to guide my thinking around suitable interviewees within the authority and the types of questions to be asked if interviewees could be arranged.

Semi structured interviews were then used as the primary method of data collection for the current piece of research. Robson (2002) describes semi structured interviews as an interview that has predetermined questions although the order can be modified based upon the interviewer's perception of what seems most appropriate. Question wording can be changed and explanations given, particular questions which seem inappropriate with a particular interviewee can be omitted, or additional ones included. The interview schedules planned as part of the semi structured interviews were individualised as each interviewee had a different professional role (Please see Appendix 1,2 and 3 for copies of each interview schedule).

The interview is a flexible and adaptable way of finding things out. Face to face interviews offer the possibility of modifying one's lines of enquiry. Responses can be followed up in more detail and non verbal cues can be detected which may provide a more accurate perception of the individual's constructs and feelings towards a particular subject. Such responses may not be detected in self administered questionnaires or interviews conducted over the telephone (Robson, 2002).

One of the main drawbacks of using an interview in this particular case is the issue of subjectivity. From a constructivist perspective, each individual has their own constructions of their social environment and when interpreting data from each interview, it may be possible for the interviewer (who is also the researcher) to interpret the data using their own constructions which are likely to be quite different from each of the interviewees. It is therefore important to bear this in mind when analysing the data. One possible way to reduce subjectivity when analysing the data is to record the interview using a dictaphone and then to transcribe the data (with consent). The interview is therefore recorded and may reduce the likelihood of the interviewer making notes of the points they feel are most useful which would inevitably be impacted by their own preconceptions and constructions of the world. However, such subjectivity and bias may also be apparent during the coding of the data.

In addition, in this context each of the interviewees and the researcher work for the same Local Authority and could therefore report findings that reflect the authority in a positive light. There may then be an element of bias in their responses. At the beginning of each interview, the researcher did reassure each participant that their responses would be anonymous although interviewees may still feel the need to answer questions in a way that

reflects the authority in a positive light. This possibly of bias will need to be acknowledged throughout the research process.

3.5 Participants

Four participants were interviewed as part of the current piece of research. Their roles were as follows: Educational Psychologist (EP), Project Coordinator (PC), and Designated Teacher (DT). These individuals were selected as they represented external support agencies, those that work directly with LAC in care homes and also within schools and could therefore provide an overview of the needs of LAC from each of these perspectives. Within the local authority, there is a specific team dedicated to working with LAC. The EP works on a part time basis for the LAC's team alongside two other EPs. The PC works for the LACs team on a full time basis. The DT works in a local special school for children with emotional and behavioural difficulties. (See the interview transcripts in the Appendices 4, 5 and 6 for more detailed information around each participant's role within the local authority).

3.6 Procedure

Informed consent was gained from each participant (See Appendix 7 for a copy of the consent forms). The consent forms included information about the use of a dictaphone and participants were given the choice at the beginning of the interview to refuse the use of a dictaphone. None of the participants did so. In accordance with ethical guidelines published by the British Psychological Society, participants were also told that they had the right to withdraw from the research without giving a reason and that any information collected from

them to date could also be withdrawn. Participants were also informed that their views would be anonymous, that is their names would not be mentioned as part of this research although their job titles may be referred to.

All of the interviews were conducted in a private quiet room and lasted between 30-45 minutes (see Appendices 1, 2 and 3 for individual interview questions). Participants were thanked for their time and given the option to request a copy of the final report if they were interested in further reading. A copy of each transcript was sent to each of the participants to ensure that the views reported in the research were indeed an accurate reflection of the views they hold. Participants were given an opportunity to amend or add any further information before their interview transcripts were analysed.

3.7 Epistemological stance

Traditional research within educational psychology has largely relied upon methods associated with a positivist approach, relying on statistical analyses and interpretation with a view to discovering an external, objective reality. In contrast, paradigms such as constructivism deriving from philosophical relativism maintain that there is no external reality, there are only different sets of meanings and classifications which people attach to the world (Robson, 2002). More recently there has been a growing body of literature within educational psychology that attaches significance to the social context of learning and the interrelationships between learner, activity and context through which constructions of reality are formed (Rust, O'Donovan & Price, 2005).

Semi structured interviews were used as the primary method of data collection for the current piece of research. Semi structured interviews allow the person being interviewed to be much more flexible in their response (Miller & Crabtree, 1999), they also allow the researcher to gain an understanding of the interviewees perception and constructions of the world and therefore reflect a constructivist epistemology.

3.8 Analysis

Interview transcripts were analysed using thematic analysis. This is a method for identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). For the purpose of this research, inductive thematic analysis was used (See Appendix 8 for a more detailed account of the process used to identify themes from the interview transcripts).

3.9 Results

Thematic analysis was used to identify themes from the data. The initial part of this process involved coding specific data extracts from each of the interview transcripts (see Appendices 4, 5 and 6). Initial themes were then identified from the coded data. These were presented in the form of a visual map (see Appendix 9). There were seven main themes identified in the initial map, these were as follows; attendance, stability of placement, role of the EP, projects, communication between agencies, care homes and lack of staff. The thematic map was then developed further showing six main themes. Looking at the original data and the initial thematic map, it was decided to expand some of the data to include a training theme and take away two themes, communication between agencies and a lack of staff. Whilst these clearly

are important points, I felt that there was not enough data to generate main themes from them. The final thematic analysis is presented below.

Table 2. A final analysis of the main themes identified.

Main theme identified	**Themes from the coded data extracts**
Attendance	Biggest barrier to learning for LAC
	Attendance workshop promoted in the homes
	Homes provide incentives
	Low attendance more likely to lead to breakdown in placement
	Difficulty getting kids out of bed
	Influenced by peers in care homes
	Need more staff on school run in the morning
	Key for LAC
	Have attendance week and attendance workers
Stability of placement	Local foster carers are not readily available
	Link between instability and lack of friendships
	Children travelling across the city
	Less likely to e able to settle after lots of moves
	Adolescence is a critical time
	Lack of foster carers

	Lots of changes leads to self destructive behaviours
	Huge issue for LAC
Role of the EP	Not casework
	Consultation
	Training to foster homes
	More one to one work- helping children to understand their story
Training to foster carers and care home staff	Healthy and useful
	Promotes strategies for all
	Emotional and educational strategies
	Useful in care homes as staff are not always flexible to leave
Projects	Emotional wellbeing
	Hair, beauty and sport
	Aim to raise children's own expectations
	None specifically for LAC in school but rather for all children
	Children in foster care more likely to access projects
Care homes	Need more EPs attached to care homes
	LAC in foster care have fewer behavioural difficulties and more likely to engage in projects

	Better quality of relationship in foster care
	Foster care more like a family home
	Lots of changes leads to self destructive behaviour
	Influence of older peers

3.10 Discussion- stability of placements

One of the main themes generated from all interviewees was the instability of care placements. Interviewees reported that the instability of care placements is still an issue for LAC especially for those that are at key transitional points in their lives, such as adolescence. The designated teacher felt that where children have lots of changes in care placements, their behaviour becomes more self destructive and it is almost as though children think 'I will make this placement break down before you can kick me out' and often relate being told off to being moved on. This point relates to Bowlby's (1973) concept of attachment, in particular the internal working model:

'Each individual builds working models of the world and himself in it, with the aid of which he perceives events, forecasts the future and constructs his plans. In the working models of the world that anyone builds a key feature is the notion of who his attachment figure is, where they may be found, and how they may be expected to respond' (Bowlby, 1973, p.203).

In addition, through the development of the internal working model, Bowlby (1973) claims that one develops a notion of how acceptable or unacceptable s/he is in the eyes of her/his key

attachment figures. For a child who has received inconsistent messages from their caregiver and possibly developed an insecure attachment, the development of their internal working model could be quite a negative one. In order to confirm their internal working models, individuals may engage in behaviours that encourage adults to support ideas of worthlessness and unacceptability which further promotes a negative sense of sense. Perhaps then thinking such as 'I will make this placement breakdown before you do' is one way of confirming a negative internal working model developed through a history of poor attachment. Such thinking also provides individuals with a defence mechanism that prevents them from feelings of being let down by key adults in their lives.

Interviewees also reported that there are many children travelling across the city to come to school because they have been moved to a placement that is not near to their school, often due to the lack of available foster carers in the local area. For those individuals that may already be demotivated, the extra distance to come to school only makes getting out of bed in the morning more difficult.

National indicators (DCFS, 2009) show that on average across England, 10.7% of LAC as of March 31st 2009 had experienced three or more care placements within the previous 12 months. The Local Authority that the research was conducted within has a higher than average move of placements with national indicators showing that 12.8% of children had experienced three or more changes in placement between March 31st 2008 and March 31st 2009. In comparison to the same statistics from 2006, this local authority has shown a reduction in the number of children who have experienced three or more changes within 12 months of just 0.4%. By comparison, a neighbouring authority has decreased the number of

children experiencing three or more placements per year from 13% to 5.2% between 2006 and 2009. It would be interesting to explore the structure of support for LAC in this neighbouring authority.

Table 3. National indicator 62. The percentage of children looked after at 31st March with three or more placements during the year ending 31st March, by Local Authorities. (DfCSF, 2008)

	2005	**2006**	**2007**	**2008**	**2009**
England	13.7	12.9	12.6	11.8	10.7
County	14.3	13.2	12.9	12.7	11.3
Local authority	16.4	13.2	12.1	13.3	12.8
Comparison local authority	13.0	9.4	10.4	9.4	5.2

This supports research that has shown that instability in both home and school placements is likely to contribute to poor educational outcomes (Jackson, 1998; Francis, 2000; Jackson & Thomas; 2001, Stein, 1994). Moreover instability at home may lead to behavioural difficulties at school and thus a risk of exclusion.

The DCSF (2009) has stressed the need for local authorities to provide stable placements although in this authority, the instability of care placements still continues to be an issue for

LAC which given the associated educational outcomes is really quite a pressing issue. It is therefore essential for EPs to attend annual reviews for LAC and promote the stability of both home and school placements by referencing the psychological research and evidence base that supports the stability of placements for LAC.

3.10.1 Care homes

Interviewees also expressed the view that children's behaviour, attendance and engagement in project based work was better when children were placed in foster care rather than a care home. One interviewee suggested that this may be because individuals feel like they belong to a family and therefore are motivated to do well for others as well as themselves. Interviewees also felt that where there were a number of children of different ages in one care home there was a risk of engaging in negative recreational activities and giving into peer pressure. One interviewee felt that this related to attendance; that is, if one child would not get out of bed in the morning then it encouraged the others not to go to school either. In addition, if the group are out until late at night they are more likely to sleep in when they should be at school. Whilst older children are generally less likely to be fostered, perhaps foster homes might reduce the modelling of negative behaviour amongst groups of peers and provide children and young people with a family home that encourages them to want to do well for those around them.

Local statistics demonstrate that in 2000, 73% of all LAC went into foster care. 33% of those placements were provided by the council. 9% of children were placed in children's home or hostels, and 4% of that 9% were placed outside the authority. These figures have remained the

same from 2005-2009 (DCSF, 2009). Whilst this demonstrates that there are fewer children in care homes, it certainly does not demonstrate a move towards placing more children in foster homes as opposed to children's homes.

Research from Jackson and Ajayi (2007) demonstrated that improved educational attainment has been linked to planned long term foster care placements which are an integral part of the education system that can raise the aspirations and attainment of LAC and play a major role in enabling more children to access higher education (Jackson & Ajayi, 2007). EPs should therefore review and consider such research when participating in decisions about a child's placement and where possible promote the use of long term foster placements. Of course, such decisions are also governed by the local availability and costing of such placements which would need to be considered as part of the local authority's budget. Where foster placements are not available, the quality of provision, stability and care in residential homes should be supported with regular training and input from EPs. This role would involve the direct application of current research to educational settings such as consultations with care staff, annual review meetings and foster care panels and therefore is a role that can be filled specifically by an EP.

3.10.2 Training and the role of the EP

The PC interviewed said that care homes had reported that they found training sessions delivered by the Educational Psychology Service were more accessible as they were delivered to care staff in the care home which meant that more individuals were able to attend. Sometimes due to the nature of shift patterns, care home staff are unable to attend training so

it seems more useful when the EP can deliver training in the homes at times that are convenient to members of staff. The DT had not received training that referred to specific psychological theories that might apply to LAC but felt that years of experience had given her an in-depth knowledge of some of the difficulties that LAC may have. She did feel that training around psychological theories such as attachment would be useful both for herself and other colleagues who had recently joined the school. Bomber (2007) argues that 'we need such understanding as education staff or else we are working in the dark.' (p.47).

Whilst training delivered by the EPs within the LAC team seemed to be valuable, interviewees felt that it would be useful to have individual EPs attached to each children's home to offer more therapeutic advice and consultations with staff. The DT also felt that more individual therapeutic work within the context of the school would also be valuable, particularly in helping children to understand their own story and identity. She felt that EPs could work more closely with individual children and young people to help them to make sense of their emotional reactions to events in their life and from a coherent story about their history and identity.

The EP interviewed reported that the EPs within the LAC team would not engage in individual casework but rather offer a consultative service to schools and carers about the needs of LAC as well as providing training. It seems from the small number of those interviewed that there may be a mismatch between what the authority are able to provide and what schools might actually want from the EPS to meet the needs of LAC. Perhaps this is an area for further exploration both from a research and service perspective. However whilst EPs

may want to provide more individual therapeutic work for LAC, a commitment to local authority work may prevent them from doing so.

Guidance from the DfES (2005) and the British Psychological Society (2006) suggests that EPs should provide training courses to school staff and residential workers about the psychological needs and provision of LAC. This appears to be a crucial part of the role which this local authority appear to be delivering. The guidance also suggests that EPs also have a role to play in assessment and intervention for LAC which may include gathering information about the child's early history, views of other professionals involved and information about their current educational and care placements. EPs therefore have a role to play within individual casework. In this Local Authority, the EPs working for the LACs team do not engage in individual casework although they do offer a consultation service to schools. Individual work might be carried out by the schools EP if the child/young person is raised at a planning meeting for example. However, the DfES (2005) recommends that EPs working with LAC have at least three years experience and a wealth of knowledge around supporting the often complex needs of LAC. Whilst the school EP may have a wealth of general knowledge, it seems more appropriate that where individual casework is needed for a LAC it should be a specialised LAC EP who carries out or at least supervises that piece of work. EPs therefore do have a role to play in assessment and intervention and such work should be carried out by those EPs working for the LACs team. In reality, there are not enough EPs within this team to work individually with those LAC who may benefit from more long term, therapeutic based work with an EP and thus the team would benefit from the recruitment of more specialised staff.

3.11 Summary

The themes drawn from the three interviews with an EP working within LAC's services, a DT from a local school and a PC suggest that this authority works closely with schools to promote the attendance of LAC and provides a number of projects that aim to enhance both academic and emotional wellbeing. However it seems that the attendance at both school and extended school activities for those children in care homes is still an area of concern. All of the interviews felt that children demonstrated better outcomes when they were in stable foster homes rather than care homes. The interviewees also felt that the instability of placements was still a key issue for LAC. Both local and national statistics demonstrate that little has been done to reduce the number of changes in placements that children experience over the last four years, despite recent documentation from the government (DfCSF, 2009). It therefore seems that these are two priorities of action at both a national and local level to enhance both the academic achievement and overall wellbeing of LAC.

3.12 Recommendations

- To enhance the stability of placements, perhaps through providing more training around the psychological principles of attachment and associated behaviours to care staff and teachers and to ensure that an EP is available to attend all annual reviews.
- Reduce exclusions for LAC by providing temporary small group support within the school facilitated by a member of staff trained in the needs of LAC.
- Reduce the number of care homes in the Local Authority and enhance the number of foster carers available locally. This may require more promotion and incentives to

become a foster carer and is more expensive. Ensure all carers receive regular training from the EPS.

- Employ staff whose role is to facilitate school attendance in the morning for those children in care homes.
- Increase EPS support specifically for children's homes and hostels.
- Specialised EPs to provide more therapeutic work within the context of school or the home.
- EPs to support the running of specific groups for LAC such as enhancing self esteem or building social skills.
- Promote the idea of resilience and emotional wellbeing within training sessions delivered at both a school and foster carer level.

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3.13 APPENDICES

Appendix 1- Interview questions for participant 1

Appendix 2- Interview questions for participant 2

Appendix 3- Interview questions for participant 3

Appendix 4- Interview transcript for participant 1

Appendix 5- Interview transcript for participant 2

Appendix 6- Interview transcript for participant 3

Appendix 7- Consent forms used for each participant

Appendix 8- Using thematic analysis

Appendix 9- Initial thematic map created from participants transcripts

Appendix 1- Interview questions for participant 1

- Introductions
- Confidentiality
- Tape recording
- Consent
- Availability of report

Interview questions:

Improving the educational attainment of children in care promotes the following actions at a local authority level:

- A senior member of staff should be responsible for monitoring the attainment of CiC
- All schools should know who is looked after in their school
- High quality PEPs should be in place and where possible one to one support for the child
- Should track and monitor data
- Promote the stability of educational placements
- And track attendance

1. Who is responsible for monitoring the attainment of CiC?
2. How are schools made aware of who is looked after in their school?
3. How are the PEP's monitored?
4. Who completes the PEPs with the child?
5. How are young peoples views gained?
6. How is data on CiC monitored and tracked?
7. How do the LA promote the stability of placements?
8.How is attendance tracked?
9. What interventions or additional support are put in place by the authority for CiC?
10. Have these interventions been evaluated? If so how? What were the outcomes for CiC?

Thank you for your time.
Reminder about report

Appendix 2- Interview questions for participant 2

- Introductions
- Confidentiality
- Tape recording
- Consent
- Availability of report

Interview questions:

1. Can you tell me more about your role within LACES?
2. Can you tell me about some of the projects that are available for LAC?
3. Research has shown that there are many positive links between participation in extra curricular activities and educational attainment, what extra curricular activities does Birmingham offer to support LAC?
4. Are the projects effective? How are they evaluated and what are the outcomes for LAC?
5. Are there any differences in terms of participation levels and outcomes for children in residential homes compared to foster care?
6. What unique contribution do you think Educational Psychologists make to LACES?
7. What do you think Birmingham do well to support the needs of LAC?
8. Do you feel that Birmingham could do more to support the needs of LAC, if so what kind of things would you suggest?

Thank you for your time.
Reminder about report

Appendix 3- Interview questions for participant 3

- Introductions
- Confidentiality
- Tape recording
- Consent
- Availability of report

Interview questions:

1. Can you tell me more about your role as a designated teacher?
2. How do you identify LAC within your school?
3. What interventions or support do your school offer to LAC?
4. How do you monitor the progress of LAC? Who is this info reported back to?
5. Is the attendance of LAC an issue in your school? How do you manage or support attendance for LAC?
6. Have you heard of the Personal Education Allowance? If so have you been involved in helping children to decide what the money is spent on?
7. Can you tell me about some of the projects that are available for LAC?
8. Research has shown that there are many positive links between participation in extra curricular activities and educational attainment, what extra curricular activities does your school offer to support LAC?
9. Are the projects/interventions effective? How are they evaluated and what are the outcomes for LAC?
10. Do you feel that you have an indepth understanding of some of the psychological theory that underpin attachment difficulties and behaviour?
11. On a scale of 1-10, 1 being not very confident and 10 being really confident, how confident would you say you were using the psychological theory that underpins attachment difficulties?
12. On a scale of 1-10, 1 being low and 10 being high where about would you place your knowledge base of the psychological theories underpinning attachment and difficulties that LAC might experience?
13. Do you think you or other staff might benefit from support around how to support LAC children from the Psychology Service?
14. Is your schools Educational psychologist involved with LAC in your school?
15. What unique contribution do you think Educational Psychologists make to LACES?
16. What other services do you feel Educational Psychologists could offer to support meeting the needs of LAC?
17. What do you think Birmingham do well to support the needs of LAC?
18. Do you feel that Birmingham could do more to support the needs of LAC, if so what kind of things would you suggest?

Thank you for your time

Appendix 4- Interview transcript for participant 1

Is it their responsibility to monitor the data for LAC?

Overall, yes. An individual tutor or member of staff may take a responsibility as well but it's their duty to overall manage that data on LAC.

Within this local authority, is it yourself X and X that work for LAC's services?

Yes, we make up altogether 0.6. So you have got the issue of what are the responsibilities and role of every EP and then you also have the roles and responsibilities of the LAC EP's?

And what would you say are the main differences between them?

Well we have special time dedicated to working with the LAC's team and overall goal is to raise the attainment of the children. Now within that we tend not to have a specific role around casework so its not party of our role to take up cases for children who may need statutory assessment for example. We do offer a consultation role so that outreach team and learning mentor can consult us about a case. They may approach us if they have not been able to approach the visiting EP. So we have a consultation role, it's possible that we could do a piece of casework although it would not be a long term involvement. We may step in and go to a review if children sometimes fall between EPs if they have moved back to the authority and their case has not yet been allocated but an important meeting is coming up. It could be that we might step in and attend that important meeting so an EP is represented. However, we would not take on the case as long term casework.

You also have the AEP produced guidance around EP's working for LAC's services which includes some recommendations which might be worth have a read of.

Does your role include training and promoting psychological theory?

We have quite a major role in training for both residential homes and schools within clusters.

And is that training focused around the needs of LAC specifically when delivered to schools?

Well it is done with LAC in mind but when you do the training sessions they include strategies that are all good practice for all children. Schools usually call you in if they have concerns around a LAC child, so we have done training on attachment and ASDD and we have focused within those training sessions on LAC children, which may also include ADHD and how does this relate to the needs of LAC who have those additional difficulties.

Are there any specific interventions that LACES or Eps are running to increase the attainment of LAC?

Its sort of a thrust of the LACES work all the way through really . When consulting with a school about LAC they might be doing some individual work with them or they might be advising schools on how to meet their needs and this may be in terms of educational as well as emotional needs. Often if the children are unsettled and not attending, then their educational needs will not be met anyway so often emotional needs need to addressed as well as looking at their educational needs.

So at the consultation levels, there are strategies and advice that promote both the educational social needs of LAC?

Yes.

Then more specifically, interventions like the personal education allowance are also happening, is that right?

Yes, the Pea is one and also as part of the LAC team there are people who run lots of projects around the city and the outreach team very promote those projects. There are all sorts of projects going on, it can be things like hair and beauty courses, dance and drama or theatre trips and they are all about raising attainment and giving LAC life enhancing opportunities that other children may have via their own family.

So under the broad umbrella of attainment, some of these projects seem to focus on raising self esteem and emotional wellbeing as well as educational attainment, is that correct?

Absolutely which will hopefully have a knock on effect in terms of raising educational attainment aswell. And its also about raising aspirations, a huge part of what we do is about raising children's aspirations and their own beliefs that they can do well and their own desire to do well and that's where these additional projects come in aswell.

In terms of your training role, are you involved in training for foster carers?

It varies actually social services do some training as do some private agencies. The head of LACES contributes to training for FC. We have just adapted some newly arrived training materials to LAC. We did it initially to deliver to residential homes who had taken a lot of newly arrived children but now many newly arrived children are going into foster placements and not assessment hoes so we have adapted the training for FC and are now looking for a mechanism to deliver to FC.

You have already covered many of the questions that I came with, I also wondered how the personal education plans for LAC were monitored?

At the child's care review which is held annually, one of the responsibilities is to review and revise the PEP.

And how much of a role does the child have towards designed the PEP?

They should have a very active role as the PEP is about them and they need to understand that they have chosen some of the targets. It would probably be the designated teacher that completed this with the child in school but it could also be their social worker.

And how is data on LAC monitored?

Well certainly for the attendance data, LSAC take weekly information from the children's home on children attendance and hold attendance weeks where the whole week is around promoting attendance. There are three attendance workers who go out into the home and promote attendance which is one of the biggest barriers to learning for LAC.

LACES also monitor and calculate attainment data.

The recent document Improving the Educational Attainment of Children in Care produced by the DfCSF (2009) promotes the stability of placements for LAC. I just wondered how the authority promote the idea stability of placements for LAC or is this still an issue for the authority.

Yes, it is still a big issue, a huge issue. If you look from a practical level, a child may be living with a foster carer and go to a school all within roughly the same area. Even when a child comes into care their first placement may not be near their original first school so you have an issue. If a child is well settled in school, attending, achieving and happy the aim is not to loose their school placement but equally you can end up with children travelling across the city. A secondary aged child who was capable of travelling then might be expected to travel independently which may include getting two buses across the city. This might be ok for a motivated child but for a child who is not motivated to go to school or if there is lots of trauma going on in your life perhaps around coming into care or a foster placement this may be where a placement breaks down. At some point someone has to make the decision, should the child continue at their previous school or do they move schools to be nearer to their placement and that does happen. Sometimes things may break down more than once, sometime there is a whole chain of placements breaking down and LAC have several school placements. The ideal situation would be to try and get the child a place near to their current school but foster placements aren't always readily available exactly where you want them so sometimes a child moves and it is not near to their school.

What are the kind of the reasons for breakdowns in placements?

Well sometimes when school placements break down, we work really hard with schools and encourage them not to exclude LAC and not to have haps in their school attendance but when a school placement breaks down that then puts pressure on the foster placement so even if the placement has been Ok some LAC have additional difficulties or events in their lives. But if your not in school for five days per week then your at home and that in itself can then lead to breakdowns in foster placements and so you can get into a vicious circle sometimes.

How does the authority promote the impact of exclusion on LAC?

Well there is a group at the moment looking at children, particularly in residential homes looking at attainment in the homes and attendance is a huge factor and school placements not

breaking down for children. Even when they first come into care, immediately they should have a school placement, either retaining a previous placement or immediately having a new one and if neither of these are possible then the children should be able to go into one of the Pupil Referral Units (PRUs) so that we don't have children coming into care couple with not going to school. So we need to recognise what the issues are and looking at what happens in the event of children being out if school.

It is one of the most disruptive things you can do for any child, it's a big issue for children to make new friends at home and school. LACES also support transition, when children move from one school to another. The more disruption you have had in your life the less likely you are to settle well and achieve so the effects of instability can become cumulative for LAC.

Appendix 5- Interview transcript for participant 2

Can you tell me a little bit about your role within LACES?

OK I am a qualified social worker seconded from the Education Welfare Service. My role is to make sure look after children get the education they are entitled too. We are making sure that education is the key to success in life to kind of raise the profile of LAC amongst professionals. I drive the message that attendance is key for LAC and we would use the same structures as those in place for other children so we will call homes and send letters home.

We have a database that we use to monitor the attendance of LAC and this includes the UPN number for the child, the allocated social worker, year group etc.

There seems to be a big push in Birmingham to increase attendance in school for LAC. Are there any other projects available for LAC that might aim to enhance attainment?

Well under every child matters, its all broken down so health for example would play a part and ensure that LAC are up to date with immunisations etc.
CAMHS, they investigate the emotional problems because obviously LAC can become distraught.

We pay for a lot of children who outside of X and I think this is due to the lack of foster carers in X.

Overall the attendance of LAC in X should be 97%

There is a lot of funding in place for LAC to increase their attainment levels including one to one tuition for children especially in year 11. Attendance is a big issue and even getting the kids out of bed in the morning.

Sometimes staff have to just pull the quilt and drag them out and all those kind of things because some of them don't want to go because they are being bullied or maybe they don't because of something that's happening at home.

I don't think you should talk or listen to what school staff say so that's really interesting but they can visually see what it looks like and the frustration and then they get some sort of funding, and they have done well for themselves come and talk nicely about what motivated them and how hard it was for them to get back on there feet, you know you really have to try and work through but you know if you stick with then look what can happen.

We had the saxophone player who was successful, you know you have kids saying that you motivated me to follow my dream and stuff like that. One girl there who wants to be a model you know for them, seeing that the other side just because you are in the situation now , you know you really can rise to above it. The attendance week is really to focus heavily on you know how to go on to college or whatever you want to do to achieve your goal, we run those in all the homes, we don't do the disability homes. One attendance project in one of our bases last about a term. Attendance is banded and the goal is to get to gold by the end of the term,

so wherever you are purple, orange, green you have got to get the gold basically. When you get to gold your given a personal coded letter band and it tells those who run the projects in school as well.

All these projects have been run in schools and what we have done is adapted it to run in the homes. Half way through they might start up with 80 one week it might be 80 for a few weeks then down because something at home or something will make them go down to 30. We are trying to work more closely with staff to help the children get to that gold. Some do well throughout and it's all displayed on a board in the home in the education room so they can all encourage each other.

Then we do the big spotlight on attendance

We have the same responsibility as parents do as corporate parents to ensure that the children are at school. You go to many of the houses and kids are just there because staff cannot get them to school but there is not a lot that staff can do sometimes and you do sympathise with them because of that.

The thinking there is a whole list of things staff can do, then there is money that you can use to kind of motivate kids.

For those children who have had numerous placements are living further away from school, do you think its hard for them to get motivated, get out of bed and get two buses across the city to get to that school?

I think what I always say is we have got kids travelling from x going over to x and its becoming more and more an everyday expectable part of life now because not everyone wants to send there children to the local school.

If these children were given a school over the other side of the city they would be running there on three or four buses at 7 o'clock in the morning do you know what I mean. But we do realise it is hard to go from one end of the city to the other but do have children coming from x to x because they love secondary school. I had to take issue one registered manager who would not let this girl because of the snow when staff were coming in on the bus and going home on the bus but she wanted to do the same and they would not let her, you know what I mean, so I had to go over his head then because how dare you its hard enough as it is without you going off, there are a few who still garble his argument was that buses were coming off so what go and get the child or do you know I am sure you can put the things into place even if it's a foster parent who lives in the area can put this child up for the night who was stranded over at that school or you know.

What unique role do you think the educational psychologist could do?

The training has been very very useful in the homes because staff cant always go out to do training because they are needed there in the home all the time and its about getting cover isn't it. But I think it's been really helpful and healthy when our ed psychs have gone in there and talked and done training sessions on autism or ADHD. We just don't get that input otherwise. Outside of the role, we all have a basic understanding of autism or ADHD but if

you have a looked after child in there who is dealing with trauma as well as special needs then staff see the behaviour and trying to deal with a complex situation that staff do not always understand. So what has been really valuable is the EP coming in and running something that's someone has asked for and also going into schools and talking about the impact of being LA.

So on peers in the classroom and peers who have also been LA?

Yes. That was one of the biggest things I had to put down for them.

What other things do you think Birmingham do well to support the needs of LAC?

There was just lots of things like time out of school there is actually a separate provision for our LAC and this might included a six week course with the fire service, running, beauty or football coaching. You can have your own adviser so there are lots of projects and incentives and programme like that and I am just scratching the surface.

And do you think there is anything more Birmingham could do to support the needs of LAC?

Yeh there is a long list although it's the same across the nation really. I think its unrealistic that there is only a handful of people cater for 2000 plus looked after children and I think that this team that we have is what is similar to what smaller authorities might have and yet we have the most LAC we certainly need more staff within this district to work more in children's homes. You need more people in the homes to get the kids out of bed and support the school run in the morning. They certainly need to have in the care homes specific staff to transport kids.

There are just too many kids who have just come into care and might have seen that other children are not going to school because they are on part-time education, or they are refusing to go, so they come to a home where it looks like you don't have to go to school. I think the three bedded units are more like a home.

Is there anything else that you want to add?

We are working constantly to improve training for residential care but I think we need a higher level of staff such as EPs especially when we are dealing with young peoples complex emotions.

I recently met up with an adult who used to be in care and he was relaying his experience from a perspective that we just don't see and he said that was clear which staff really genuinely cared and which staff were in it for the job. He could name three members of staff that had really positive relation shops with, one of those was the activity coordinator. He would take them out canoeing which they enjoyed but you don't hear about staff taking kids out like this anymore and therefore how can you influence kids if you don't develop that relationship with them. It's quite dismal the whole residential care situation relationship.

So staff are asking the young people to get out of bed in the morning but there is no negotiation if there is no relationship because they have to have that element of trust?

That's right. Sometimes other incentives have worked such as offering a kid a pound a day in addition to their pocket money and for some kids this does work but for a lot of kids who we want to reach it's the relationship that they want.

And do you think that the raining that the eps have delivered has helped to promote the quality of relationships between staff and young people?

I think it's the same as the care staff issue, we just don't have enough. We could do with having an EP assigned to each care home. They have delivered some good training but you know its needs to be delivered probably termly because not all staff would be there to access it and also you might take buts from to and then forget other bits.

Are there any differences in terms of participation levels and outcomes for children in residential homes compared to foster care?

Whenever they put on any event and the adverts go out you can guarantee
That 95% of time the foster care kids will be there but there is a difference for the care homes. Staff will often report that it was too difficult to organise and don't drive it from the home.

And is that the same as in terms of outcomes for LAS in foster care?

It's the relationships again. The quality of relationships seems to be better in the context of a foster home.

And is homework done in the residential homes?

The good homes there is an education room and children will be asked to do the homework before they go out as you might expect in your own home you know.

It's harder to create a home like environment in a 8/9 bedded house with year 10s, 11's and maybe 1 year 7.

Appendix 6- Interview transcript for participant 3

1. **Can you tell me more about your role as a designated teacher?**

Well I am actually a team leader for LAC on this site as the school is separated into two sites and I deal with all the young people who are in local authority care whether it be from a care order or section 20.

2. **How do you identify LAC within your school?**

Usually when young people come into the school, they already have a statement of special educational needs. We also have information about whether the child has a social worker and which other agencies are involved, i.e. YOT so we know when a child initially comes into the school if they are looked after.

3. **What interventions or support do your school offer to LAC?**

In this school all the children can access the facilities and initiatives on offer so there doesn't tend to be anything specifically for LAC. They are not singled out because they are LAC. They can go to sports activities or extended days which are where activities are out on for young people after school. This may be football, cooking, various classes, and any recreational activity really out of school hours.

4. **How do you monitor the progress of LAC? Who is this info reported back to?**

Well in terms of attendance, if a LAC child was not attending school we would look at getting LACES involved. Before that it's the usual procedure of calling homes, getting EWOs involved.

5. **Are there many children in residential homes on this site?**

On this site there are two in children's home. There is a difference between being in foster care and a care home. If they are in foster care there behaviour tends to be better.

6. **And why do you think that is?**

I think it's because they feel like they are part of a family and they are part of a routine which makes them feel more secure and safe. However, when they go to a care home, if other children are not going to school they tend to follow suit. We had a LAC who was in foster care for a long time, that broke down and he went to a children's home and now he just tends to do what he wants, doesn't always get up to come to school and his attendance has deteriorated.

7. **From your experience, do children tend to change foster carers regularly?**

I think it depends on their age. When they get to a certain age, if they have been with a foster carer for a long time and stay with them up until they leave school everything is fine. However if you have been with a care up until you are ten and then things break down there tend to be a high number of changes after that. It may be to do with adolescence as young people can be more deviant at this age and also there may be issues about identify. Some young people have had so many foster carers that they tend to become self destructive almost like 'I will make this placement break down before you can kick me out'. We see that year after year, the children are happy with their carers but if they get told off just once they become disruptive and the placement begins to break down. They can be fine and all teenagers get told off but that's probably the first time that those children have been shouted out in that placement and from there it goes down hill and they don't come into school. I think they get to the stage where they associate being told off with having to leave yet another placement.

8. **Is the attendance of LAC an issue in your school? How do you manage or support attendance for LAC?**

Yes, and it's the usual really. Phone calls to the home, home visits, trying to get LACES on board, putting on incentives such as a trip they would like to do, e.g. go karting. Getting an incentive to get them into school. Its basically working with the children's home as well and they will give the young people extra incentives. It's about working in partnership with the children's centre.

9. **And why do you think the young people don't want to come to school?**

Sometimes they can't be bothered to get out of bed and sometimes in the children's home there might be other young people who won't attend school anyway so they will stay in bed until two and they go out together and be out all night.

10. **Have you heard of the Personal Education Allowance? If so have you been involved in helping children to decide what the money is spent on?**

That is done collectively, we identify which LAC we have got and then the SENCO on the other site completes the paperwork etc.

11. **Research has shown that there are many positive links between participation in extra curricular activities and educational attainment, what extra curricular activities does your school offer to support LAC?**

There are football activities etc although it has to be something that the child wants to do. Children in the children's home seem less motivated, they just want to go and do nothing but when they are in foster care because they feel part of a family they seem more motivated and want to take part in activities. The children do choose which activities they want to do and when they get there they actually do seem to enjoy it.

12. **Are the projects/interventions effective? How are they evaluated and what are the outcomes for LAC?**

Well one of the activities we do at the beginning of the year is a team building day out at X. We knew this was successful is because all the children brought their forms back, they turned up on time and behave themselves, abide by the rule which is a sort of evaluation although that is for all children not just LAC.

13. **Do you feel that you have an in-depth understanding of some of the psychological theory that underpins attachment difficulties and behaviour?**

I think through experience I do but I don't know if I could tell you all about attachment theory. I used to work in a children's home so I am aware of attachment theory and how that might help children in care. I think I use if more subconsciously through experience but I think more training could work for those who are just entering the profession.

14. **On a scale of 1-10, 1 being not very confident and 10 being really confident, how confident would you say you were using the psychological theory that underpins attachment difficulties?**

About a 7

15. **Is your schools Educational psychologist involved with LAC in your school?**

In the past they have been in terms of working individually with children.

16. **What unique contribution do you think Educational Psychologists make to LACES?**

I think they can help children to understand what has happened to them and that it's not their fault. The EP can give them a deeper understanding. I think children can open up more to outside agencies who they don't see as a teacher or a care worker. So I think their role could be to provide more individual support, more in-depth and one to one support that's not rushed.

17. **What other services do you feel Educational Psychologists could offer to support meeting the needs of LAC?**

To provide more individual support, more in-depth and one to one support that's not rushed.

18. **What do you think Birmingham do well to support the needs of LAC?**

I really don't know.

19. **Do you feel that Birmingham could do more to support the needs of LAC; if so what kind of things would you suggest?**

I think social workers need to see young people more often and for young people to be able to see the social worker when they want, regardless of whether its a care order or section 20, the social worker should attend plays and open days etc, not just negative meetings because when

you see their faces when nobody turns up its heartbreaking. Staff from residential homes don't always come it juts depends on if there are enough staff on duty.

There also need to be more communication between services and schools. Schools needs to know what's going on with every LAC child as their behaviour will have a direct impact upon their learning and that behaviour will be affected by what's going on at home. So when they come into school, we will be working on the bad behaviour not knowing the background and then three weeks later the social worker might tell us what was happening so there is a need to improve that communication.

Appendix 7- Consent forms used for each participant

Dear Colleague,

I am currently training to be an Educational Psychologist with Birmingham's Educational Psychology Service and Birmingham University. One of the requirements of the doctorate is to carry out a piece of research that aims to evaluate how your authority focuses on raising the attainment of a vulnerable group of children. In this case, I have chosen to focus on LAC.

As part of the research, I would like to carry out several interviews with professionals within LACES and use this information to provide a clearer picture of how Birmingham works with LAC. The interviews should last around 30 minutes and may be recorded using a Dictaphone just to ensure that I do not miss any information. Once the information has been transferred to a written form the voice recordings will be deleted. For the write up of this piece of research, your views will remain anonymous, that is your names will not be published.

If you are happy to give consent for me to use your views as part of my doctoral research, could you please read, tick and sign the information on the back of this letter.

Yours sincerely

Heather Ball
Trainee Educational Psychologist

Please indicate that you understand the following information by putting a tick in the appropriate box:

Research criteria **(Based on guidelines for minimum standards of ethical approval in psychological research produced by the British Psychological Society).**	**I understand this information (√)**	**I <u>do not</u> understand this information (√)**
The interview may be recorded on a dictaphone just to ensure that I do not miss anything. Once your views have been written down, the voice recording will be deleted.		
Your views will remain anonymous, that is your name will not be mentioned in the report although your job title may be referred to.		
You have the right to withdraw from the research at anytime without giving a reason.		
If we have already collected information from you and you choose to withdraw from the research, you also have the right to withdraw all the information you have given us to date.		
Data from the research will be kept in a secure location within Birmingham's Educational Psychology Service		
Anonymous findings from the study will be shared with academic staff and students at Birmingham University, individuals within the local authority and other members of the research community.		
Data will be gathered by a Trainee Educational Psychologist within Birmingham's Educational Psychology Service.		

I have read and understood the above information and give my consent for Heather Ball to use the data from my interview as part of her doctoral research.

Signed:…….
Date: …….

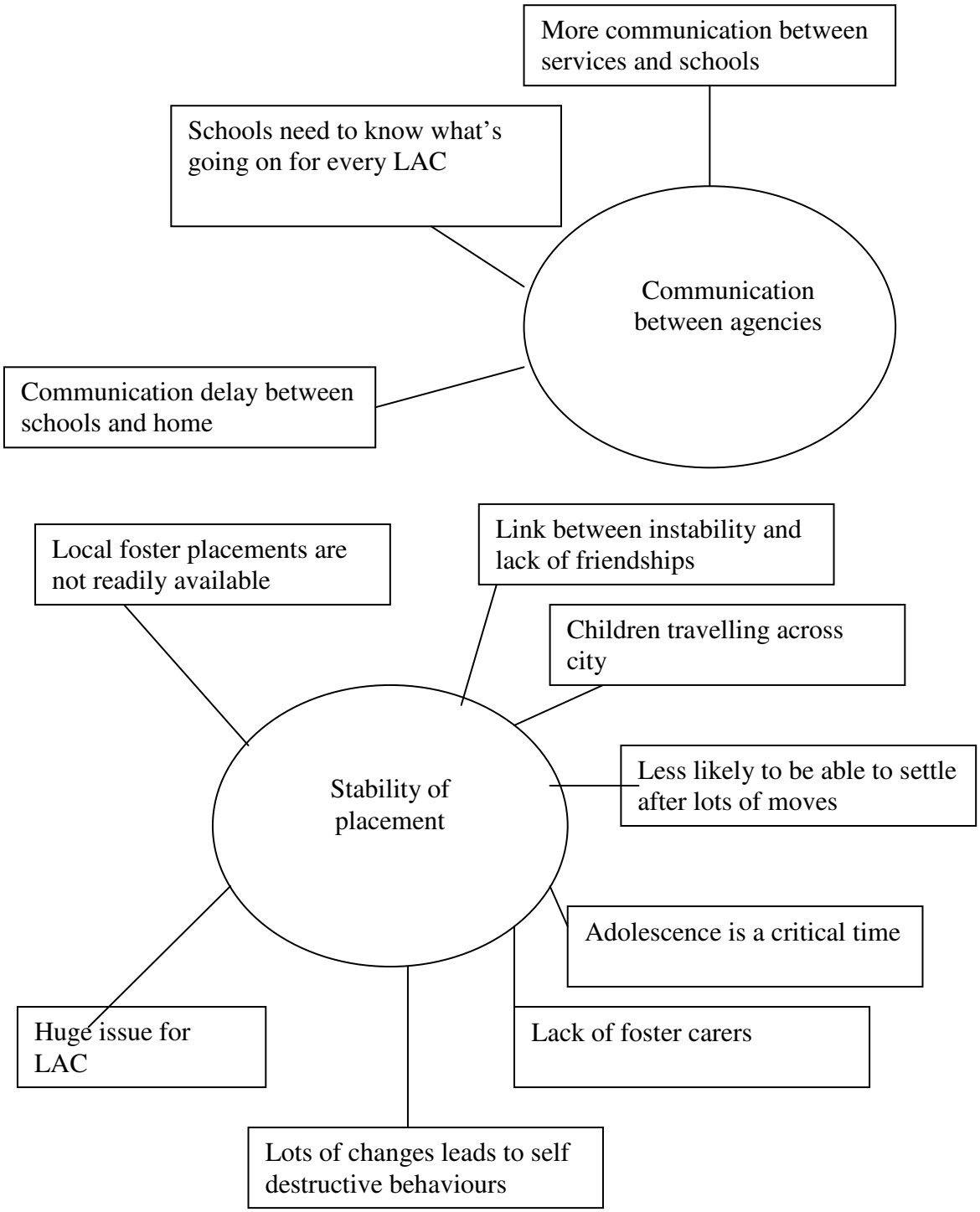
Appendix 8- Using thematic analysis

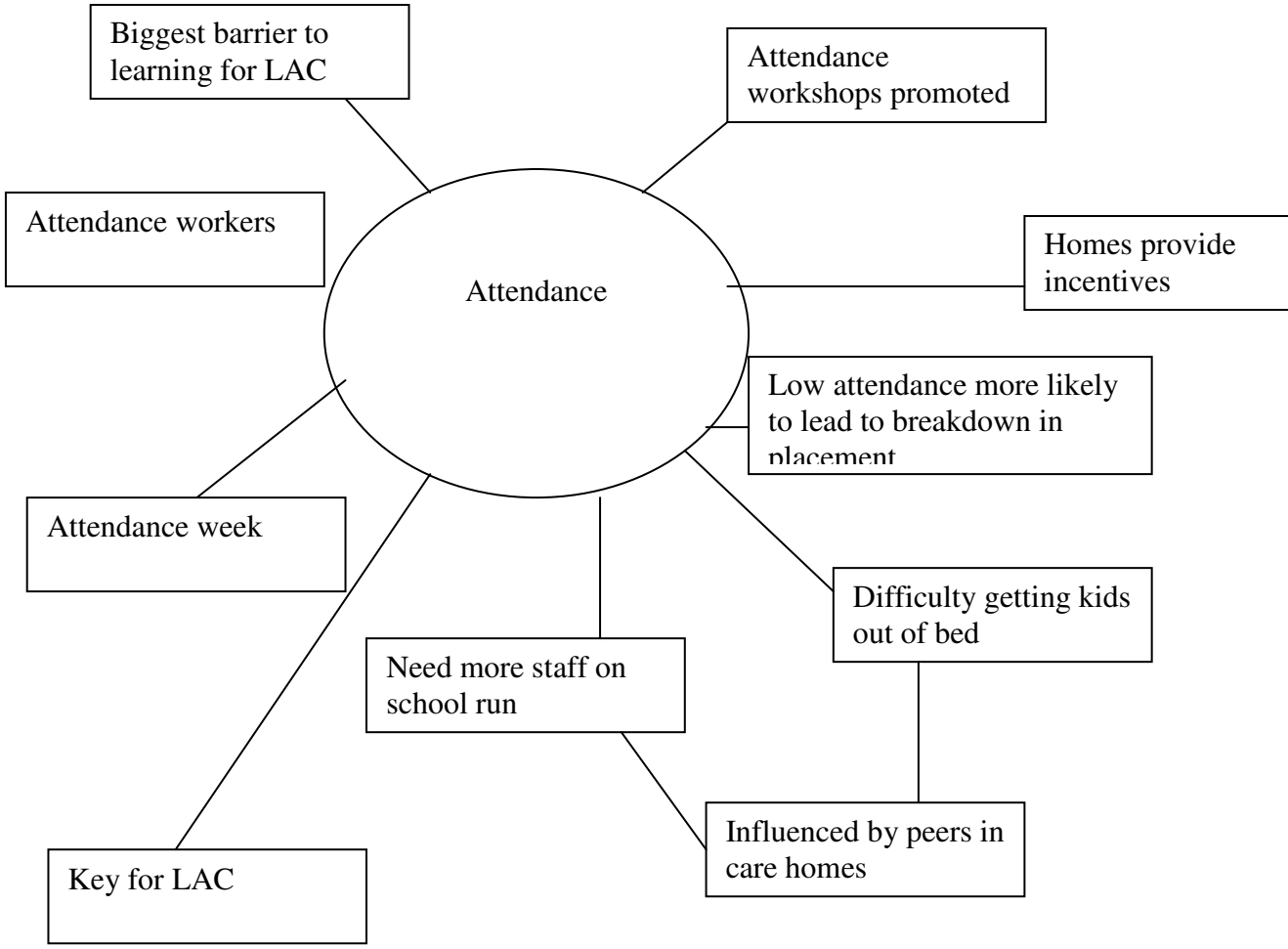
Using thematic analysis- Braun & Clarke, 2006.

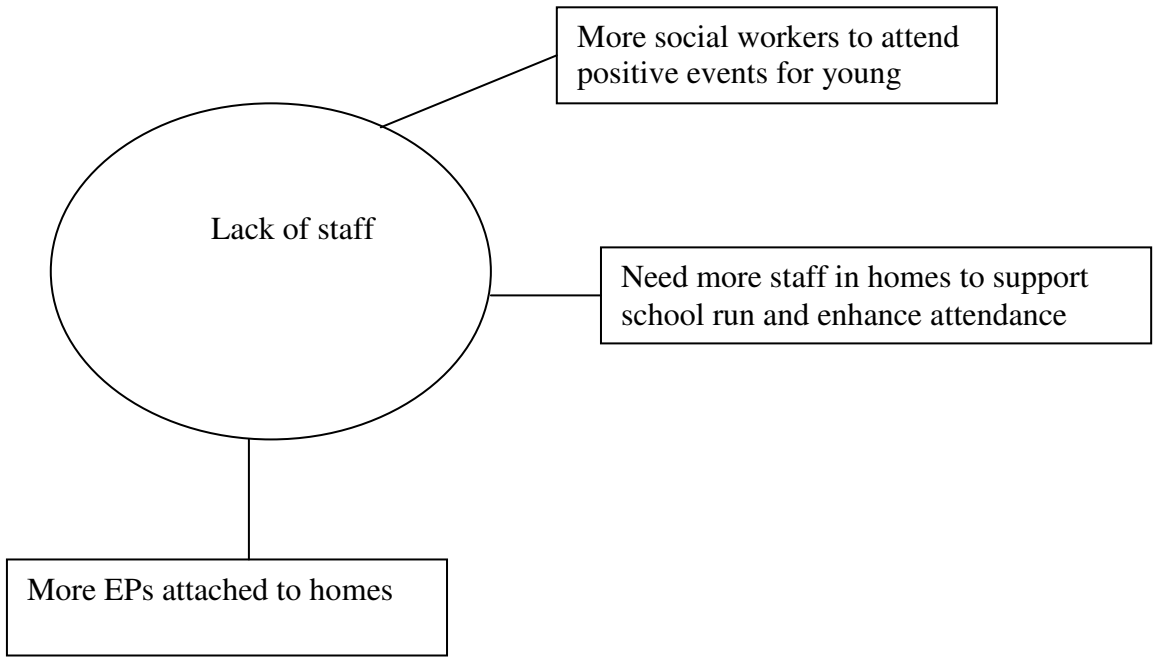
Table 1 Phases of thematic analysis

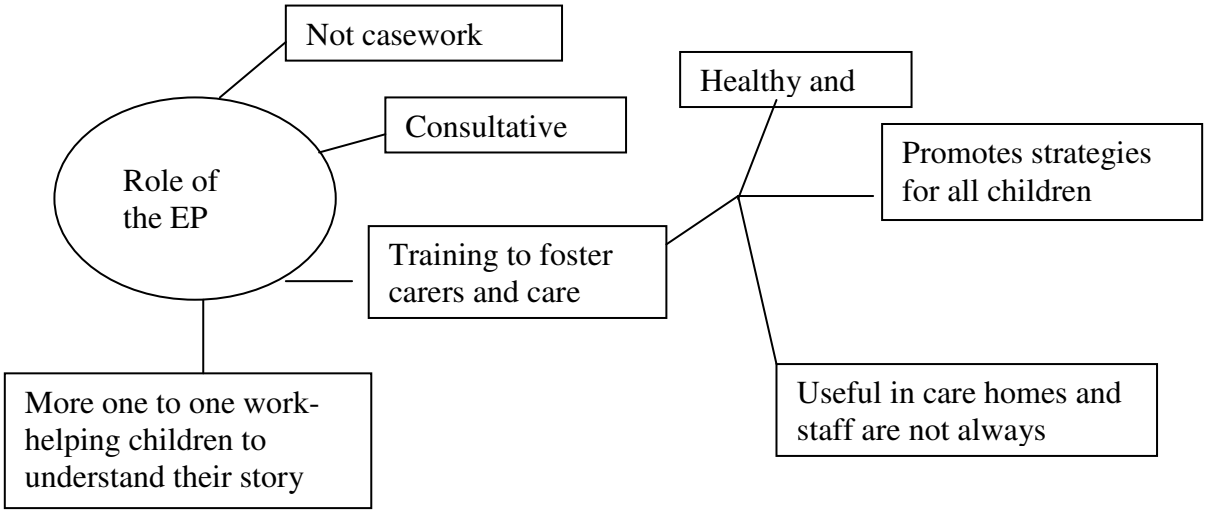
Phase	Description of the process
1. Familiarising yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviving themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

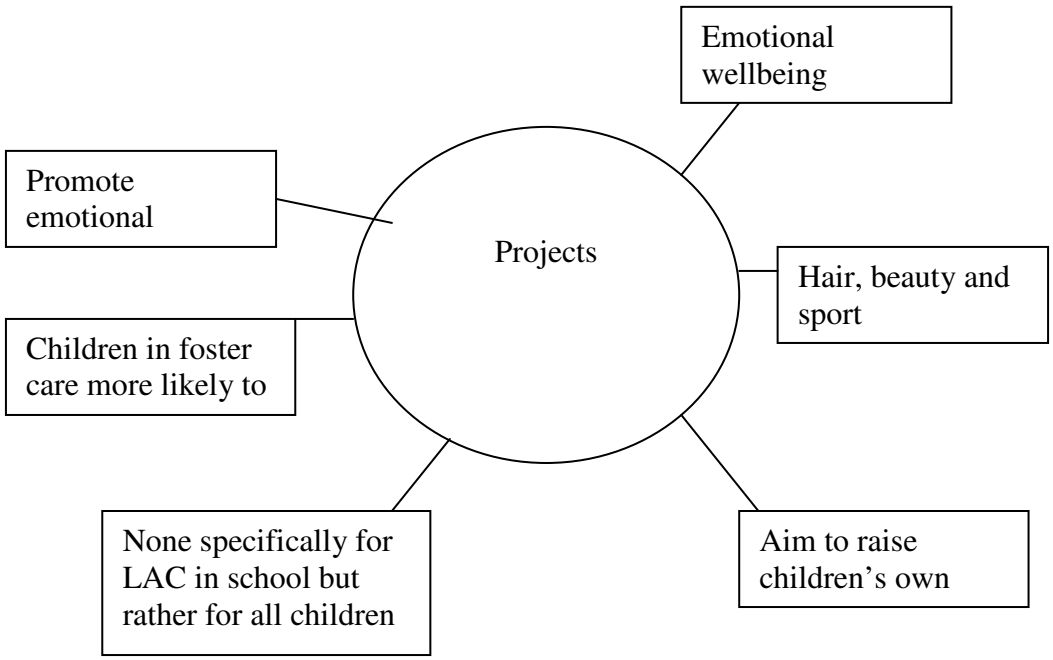
Appendix 9- Initial thematic map created from participants transcripts

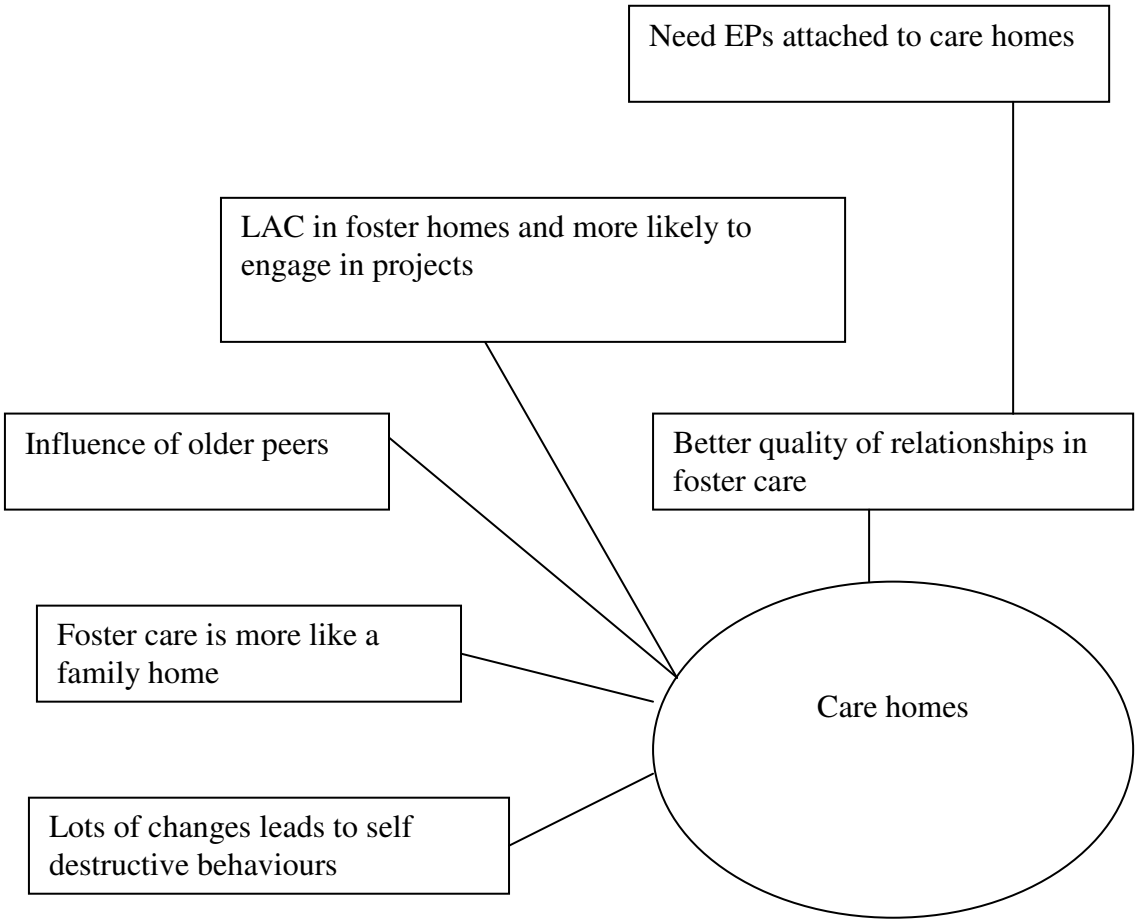



Biggest barrier to learning for LAC
Attendance workshops promoted
Attendance workers
Attendance
Homes provide incentives
Low attendance more likely to lead to breakdown in placement
Attendance week
Difficulty getting kids out of bed
Need more staff on school run
Influenced by peers in care homes
Key for LAC


More social workers to attend positive events for young
Lack of staff
Need more staff in homes to support school run and enhance attendance
More EPs attached to homes


Not casework
Consultative
Role of the EP
Training to foster carers and care
More one to one work- helping children to understand their story
Healthy and
Promotes strategies for all children
Useful in care homes and staff are not always


Emotional wellbeing
Promote emotional
Projects
Hair, beauty and sport
Children in foster care more likely to
None specifically for LAC in school but rather for all children
Aim to raise children's own


Need EPs attached to care homes
LAC in foster homes and more likely to engage in projects
Influence of older peers
Better quality of relationships in foster care
Foster care is more like a family home
Care homes
Lots of changes leads to self destructive behaviours

CHAPTER 4- PROFESSIONAL PRACTICE REPORT 3

4.1 Title

How can Educational Psychologists and Local Authorities support the needs of children of prisoners? Reflections on the role of the EP in a local multi-agency project aiming to enhance positive outcomes for families of prisoners.

4.2 Abstract

Between 125,000-170,000 children and young people are affected by parental imprisonment each year in England and Wales (Murray, 2007). Around 65% of children of prisoners will go onto offend themselves (Glover, 2009) and are likely to experience a range of adverse outcomes that may affect their social and emotional development and overall quality of life. Possible psychological mechanisms that may explain the relationship between parental imprisonment and adverse outcomes experienced by children and young people include theories from attachment research, social learning theory, witnessing domestic violence and stigmatisation and labelling. The ThinkFamily project is a locally based multi agency project aiming to reduce offending amongst children and young people of prisoners. Two Trainee Educational Psychologists (TEPs) from the local Educational Psychology Service (EPS) were approached in order to contribute a distinct psychological perspective to the project. The RADIO framework has been used to describe the key elements of the project and how our actions were negotiated and evaluated. This assignment highlights the unique contribution that Educational Psychologists (EPs) can bring to a multi professional project, namely knowledge of typical and

atypical child development, knowledge of research findings, the application of research skills and an ability to gain views of children and young people in authentic and genuine ways.

4.3 Literature review- Introduction

The prison population has increased substantially over the last decade. On March 31 2010, the total prison population in the UK was 85,184 (NOMS Annual Report, 2010) and many of those individuals are parents to one or more children. It has recently been estimated that approximately between 125,000 and 170,000 children under the age of 18 are affected by parental imprisonment each year in England and Wales (Murray, 2007, SCIE, 2010). Many of these children are school aged and some demonstrate behavioural and emotional difficulties that may hinder school related functioning. This literature review will expand further on the type of behavioural and emotional difficulties that children of prisoners may experience.

At a prison in the local area where this project was undertaken, there are approximately 1435 prisoners at any one time; it is unknown how many of those prisoners are parents. It is estimated that there are about 10,500 child visits to the prison each year with approximately 9,622 0-9 year olds and 3,216 10-17 year olds. Some children will visit the prison more regularly than others depending on geographical location, travelling distance, financial implications and parental preferences.

The Children Act (1989) states that the child's welfare shall be the court's paramount consideration and that the child is entitled to shared parental responsibility whether parents are together, separated or in prison. Children therefore have rights to see their parents in prison. In

addition, in 1991, the UK ratified the UN Convention on the Rights of the Child which places emphasis on the child's right to maintain contact with a parent from who they are separated. Thus, unless a child is known in some way, already to have been damaged by a parent, child care policy in England and Wales assumes that the establishment and continuation of contact with both parents is beneficial to stable child development (Boswell, 2002). However in reality it is rare for criminal proceedings to take into account the rights of a child when sentencing a parent to imprisonment. There are no official mechanisms in place to identify if a prisoner has children and whether they are likely to need support from professionals in the community when the parent is imprisoned. Moreover the visiting procedures and conditions for a child to maintain contact with an imprisoned parent are often far from child friendly and may evoke further distress and worry.

4.3.1 Does parental imprisonment cause adverse outcomes for children?

Murray and Farrington (2005) conducted a longitudinal research study of 411 males in London and found a strong correlation (56%) between those who had been separated from parents (usually fathers) before the age of ten and later conviction up to the age of 32 years. They argue that parental imprisonment appears to affect children over and above parental separation: that is, boys who were separated because of parental imprisonment had more antisocial- delinquent outcomes than boys separated because of other reasons. Antisocial- delinquent behaviours included antisocial personality, poor life success, convictions, self reported delinquency and self reported violence. Although parental imprisonment is a strong predictor of adverse child outcomes, this does not necessarily imply that it affects children causally. Children who have a family member in prison may also be more likely to experience individual risk, poor parenting

and family deprivation which may lead them to antisocial or delinquent type behaviours. However Murray and Farrington (2005) found that boys separated from parents due to parental imprisonment still experienced higher rates of antisocial delinquent behaviours and mental health problems after statistically controlling for other childhood risk factors. Murray and Farrington (2005) concluded that the children of prisoners are a highly vulnerable group with multiple risk factors for long term adverse outcomes. In her study of violent offenders, Boswell (2000) found that one of the most prevalent characteristics amongst the violent offenders was a significant loss in childhood, most of which was parental and a substantial amount was paternal. This suggests that whilst tentative, perhaps there is a causal link between parental imprisonment and long term adverse outcomes for children and young people.

Payne notes that:

'Imprisonment has destructive effects on a family ; the instability, the financial distress, the burdens of the remaining carers and the psychological difficulties of the child such as guilt and acute insecurity, manifesting themselves as disturbed behaviour' (1997 p.42-43).

Smaller scale qualitative studies also demonstrate a number of 'disturbed behaviours' for children of prisoners. Philbrick (1997) found that almost one third of prisoner's children suffer significant mental health problems compared to 10% of children generally. In addition parental incarceration may be associated with sadness, withdrawn behaviour, sleep problems, aggressive behaviour, deteriorating school performance, truancy, bed wetting and sometimes delinquency (Friedman & Esselstyn, 1965; Moerk; 1973, Sack, 1977). Parental imprisonment is often associated with financial hardship, feelings of loss and confusion may well be compounded by the altered financial and emotional resources of the remaining parent or carer.

4.3.2 What are the psychological and sociological mechanisms that might cause adverse outcomes for children who have a parent in prison?

Qualitative research suggests that parental imprisonment can affect children through the combined traumas of parental arrest, parent- child separation, loss of family income, changes in child care arrangements, caregiver's own distress, difficult experiences of visiting prisons, inadequate parenting and stigmatisation (Murray, 2005; Murray & Farrington, 2006). The following section will focus upon the psychological mechanisms that may contribute towards adverse outcomes for children of prisoners when they witness an arrest, are separated from a parent, have a negative experience of visiting a parent in prison and when they feel stigmatised. In addition, the adverse outcomes experienced by children of prisoners may also occur as a result of a number of factors before an arrest, i.e. exposure to crime in the household or conflict within the family.

4.3.3 The arrest

Some children may witness the arrest of their parent. In some cases parents may be arrested during early hours in the morning by officers who are not in uniform and may be armed. Operational issues therefore mean that a child will invariably be exposed to the dislocating experience of arrest and may experience negative effects on their behaviour as a result, for example bed wetting, aggression or withdrawn behaviour (SCIE video accessed 21.10.10).

The loss of a parent combined with traumatic circumstances surrounding that loss may increase the likelihood of poor psychosocial functioning due to the potential for exposure to acute

trauma (Dowdney, 2000; 2005). Such acute trauma may have been ongoing for years whilst parents engaged in criminal activities and could be further heightened through witnessing the arrest (Beckerman, 1998). Bockneck et al (2009) interviewed children whose parents had been imprisoned and found a significant correlation between children's reports of post traumatic symptoms (as measured by the Child Report of Post Traumatic Symptoms, CROPS), post traumatic symptomology and withdrawn behaviour. Typically children displayed a great deal of hypervigilance to the degree that it impaired their daily functioning and they were more likely to internalize negative feelings and behaviours. One child reported feeling isolated and different from the other children. Another child felt compelled to 'keep it inside'. Moreover, the children in this study displayed ineffective coping behaviours which suggests that children's post traumatic stress, which will be further heightened by witnessing an arrest, may be partly responsible for decreased emotional well-being and resilience.

4.3.4 Trauma of parent-child separation

The idea that parent- child separation may cause adverse outcomes for children is based on the theory of attachment originally developed by John Bowlby (1969). An 'attachment style' describes our pattern of relating to 'significant others' that is the important people in our lives (Bomber, 2007). Such attachment styles or patterns develop and evolve over our early years through experiences and interactions with our carers or parents. Affective attunement, defined as the intersubjective sharing of affect, is central to the development of a secure attachment during the first year of life and impacts on how we view ourselves and interact with others throughout our lives. Lengthy, possibly unexpected and often unexplained parent-child separations occur as a result of maternal imprisonment in addition to changes in children's

living arrangements. Children of imprisoned mothers in particular may experience infrequent and inconsistent visits to see their mother and therefore may develop insecure attachments with their caregiver. The majority of research that has been published about attachment and the impact of imprisonment has been based on maternal imprisonment. It is not known whether these findings can also be applied to paternal imprisonment or whether having a secure attachment with one's mother is a factor that may enhance resilience if one's father is sent to prison.

Poehlmann (2005) studied the representations of attachment relationships in 54 children aged 2.5 to 7.5 years whose mothers were currently incarcerated. This study was based in the United States. She found that nearly two thirds of children held representations of attachment relationships characterised by intense ambivalence, disorganisation, violence or detachment. 'These hallmarks of insecurity are not surprising given that all children had experienced prolonged separation from their mothers and one or more changes in caregivers' (Poehlmann, 2005 pp. 690). Children's initial reactions to the separation included sadness, worry, confusion, anger, loneliness, sleep problems and developmental regressions.

In Poehlmann's study, the strongest predictor of children's representations of relationships with caregivers was the stability of care. Children who lived with one continuous caregiver from their mother's imprisonment were more likely to have secure attachments with that caregiver, which may enhance their resilience to deal with adversity. A study by HM Inspectorate of Prisons found that 25% of children were cared for by their grandmothers, 29% were cared for by family members or friends and12 % were in care, fostered, or adopted (SCIE, 2010). Children who go into care are likely to experience several changes in placements which may

encourage the development of insecure attachments and this will have a direct impact on their representation of themselves, their interactions with others and behaviour. The project that is described in this report is based on children and families visiting an all male prison. However, there is currently a dearth of literature and research in the area of paternal imprisonment and attachment and thus Poehlmann's study, whilst focusing on maternal imprisonment and based in the United States gives us some indication of the effects of parental imprisonment for children who may then be cared for by someone other than their parents.

Attachment theory suggests that children cope better when they are given clear and honest explanations about separations. Poehlmann (2005) found that children were slightly more likely to hold positive representations of caregivers when they were told about their mother's incarceration in simple, honest and developmentally appropriate ways. However, in her study 20% of caregivers had told children distorted explanations (the mother is in college, at the hospital or on vacation for example) and 15% indicated that they had never said anything to the child about the mother's incarceration. Without understanding simple facts about their parent's imprisonment, children may experience reduced capacity to process their traumatic loss psychologically, or voice any preferences they may have about contact (Murray, 2003). Inconsistent explanations may therefore only add to the confused emotions that children of imprisoned parents may already be feeling.

Factors that lead to the development of intense ambivalence, disorganisation, violent attachment or detachment may of course be present in children of imprisoned mothers before they go to prison. It is difficult to identify a causal effect between maternal incarceration and the development insecure attachments. If separation because of parental imprisonment is

particularly harmful for children then children of prisoners should experience more adverse outcomes than children who may have been separated from parents for other reasons such as divorce, separation, hospitalization or death. The Cambridge study carried out by Murray and Farrington (2005) found that boys separated from parents (mothers and fathers) because of parental imprisonment experienced more antisocial problems, mental health difficulties and delinquent behaviours than those separated for other reasons. Whilst the link between these behaviours and an insecure attachment is not clear cut, attachment theory would suggest that children who experience such chaotic and insecure attachments are more likely to exhibit some of those behaviours noted above and children of prisoners are likely to develop such attachments, although the research to date only focuses upon the effects of maternal incarceration on attachment. The relationship between paternal incarceration and attachment is not known.

These findings highlight young children's needs for emotional and developmental support during parental incarceration and caregivers needs for information regarding such reactions to separation.

4.3.5 Visiting

Within the context of a local prison, in 2008 there were 7,760 visits recorded from children aged 0-9 year olds and 2,133 visits recorded from children and young people aged 10-17 year old. During the first 6 months of 2009, there were 4,797 0-9 year olds and 1,336 10-17 year olds that visited the prison. Visiting prison can be dull for children, parents may need to talk alone and activities available tend to be aimed at very young children. In addition, visitors are

not allowed to bring toys of their own to play with during the visit (Action for Prisoners, 2003). Poehlmann (2005) found that the prison she visited and conducted her research within was not all that child friendly. In this prison, razor wired fencing surrounded the outdoor play area, women were required to sit at tables during indoor visits rather than playing on the floor with children and privacy was unavailable.

Children are unlikely to be prepared for the emotional impact of their first visit and may struggle to find things to talk about with their parent in prison. Some children experience long journeys to get to the prison and often have to wait a long time before their visit is processed and they can go through to see their parents (Comfort, 2003; Grimshaw & King, 2002; Loucks, 2002). Children may end up feeling tired, irritable and wanting to go home which subsequently impacts on the quality of the visit they have with their parent and overall distress and stress of the child, the visiting parent and the prisoner. McEvoy (1999) found that of the 219 partners of prisoners interviewed, 25% said that they did not like to bring their children to visit the prison. The most common reasons given for not wanting to bring their child was that their behaviour was problematic in some way which included children being argumentative, aggressive, restless or troublesome due to tiredness or boredom.

Whilst these reports are from the partners of prisoners, research in Northern Ireland reported that many children demonstrate emotional distress and atypical behaviour both before and after visits. Such behaviour included sickness, irritability, excessive quietness or over excitement prior to the visit, restlessness, argumentative behaviour during the visit and sadness or withdrawn behaviour after the visit (NIACRO, 1994).

Boswell (2002) gained the views of children who had visited prison and reported the following:

‘ I hated seeing him on Ordinary visits at ‘X’ prison. It was a real shock seeing him in prison for the first time. I hated being searched and often had to wait an hour before being called in to see him. The officers were OK though I felt they looked down on me and I could see that some of them were bullies. I didn’t like the seating arrangements where he couldn’t move’ - Mark, 16 years. Town Visits (which prisoners are released to spend a day with their family within a 30-mile radius of the prison), (Boswell, 2002: pp. 18).

‘This prison has a crèche. The one we went to before didn’t. I like it in the crèche, but sometimes they don’t open it and I get bored’ - Julie, 8 years. Ordinary Visits (within the prison), (Boswell, 2002: pp.18).

Both parents and children are likely to experience an array of contrasting emotions during their time at the prison which may have a detrimental impact on their own emotional wellbeing as well as the quality of their visits and in particular a prisoner’s interaction with his/her children. Boswell’s (2002) research supports the need for and availability of visiting centres (Blake, 1993) where parents and children can go before and after visits to access professional support assistance around how to deal with feelings evoked through prison visits for both themselves and their children. Young children may also need additional emotional support and reassurance to cope effectively with such a prison visit so that their experience functions as a positive means of maintaining and strengthening parent child relationships (Poehlmann, 2005)

4.3.6 Stigmatisation and labelling

Families of prisoners may experience stigmatisation, bullying and social exclusion. Factors that may enhance one's resilience in the face of adversity include being part of a community, having good relationships with key adults in one's life, developing secure friendships and engaging in after school activities (Berridge, 2006). Social exclusion as a result of stigmatization may therefore further reduce opportunities to enhance one's resilience and also encourage criminal behaviours amongst children of prisoners. This may therefore contribute to antisocial behaviour and mental health problems (Boswell & Wedge, 2002).

Children of prisoners may be more likely to go on to offend themselves because of pre- existing social disadvantages, modelling parent's behaviour, social exclusion or official bias. Official bias is when children of prisoners are more likely to get prosecuted or convicted for their crimes compared to their peers because of their family name or association with an existing prisoner. If children of prisoners are more likely to offend because of official bias then there should be stronger effects of parental imprisonment on official measures of offending than on self reported measures of offending. That is, children of prisoners would report that they had not committed a crime even though they may have been arrested which will be reflected in the official measures. If there is a discrepancy between the reports of children of prisoners and official statistics, then this may suggest that official bias is occurring or perhaps that the offenders did not want to commit their crime to the researchers.

However, the Cambridge study conducted by Murray and Farrington (2005) found that parental imprisonment had similar effects on official measures of conviction and self reported offending

suggesting that official bias did not account for criminal outcomes of prisoners' children. Nevertheless, it is important to consider the influence of professional bias towards children and families of prisoners which may contribute to the perpetuating cycle of offending between generations.

As professionals aiming to support this group of children and families, it is important to consider the effects of stigmatization and respect parents and children who want to keep this kind of information from schools and outside agencies. Schools are in an ideal location to not only support families of prisoners but also to challenge negative stereotypes of the family and promote a more restorative justice system; that is, place an emphasis on reconciliation amongst offenders who have 'done a crime, done their time' and now need support to be reintegrated into society and back with their families.

4.3.7 Modelling behaviours

Children of prisoners may also be more likely to go onto offend themselves and experience more adverse outcomes because they have learnt to model criminal behaviour. Akers (1973) suggests that individuals learn to commit deviant acts through interactions with their (primarily social) environment. Within this environment, consequences are attached to behaviour which reinforce or fail to punish deviant acts to a greater extent than they reinforce conforming behaviour. Deviant behaviours may therefore be seen as more desirable than alternative conforming types of behaviour. This social learning theory is based on principles from behavioural psychology, namely the idea of operant conditioning in which behaviour is shaped by stimuli which follow or are consequences of the behaviour. Social behaviour can be acquired

through direct conditioning or through imitating or modelling others' behaviour. So if deviant behaviour is reinforced for a child through more attention, praise, acceptance or even financial reward then such behaviours are likely to continue. This mechanism is similar if a child observes an adult's deviant behaviour being reinforced through similar means. Furthermore, Akers et al (1979) argue that our evaluative definitions of 'positive' or 'negative' behaviours are reinforced through interactions with significant groups in our lives primarily friendships groups and family. The more that behaviour is deemed as good or desirable rather than undesirable by members of the 'group', the more likely an individual is likely to engage in it.

4.4 Further development of existing resources

A range of materials to address emotional and relationship issues exist, but few are in a form suitable for the audiences that need them most i.e. children and young people (Loucks, 2004).

Grimshaw and King (2002) found that a need for more information on prisoners for professionals such as those working in education was evident. The needs of caregivers and other family members required greater attention, especially information on the preparation of release. In Northern Ireland, McEvoy (1999) found that the majority of partners of prisoners sought and received considerable support from family and friends with only 11% of 239 respondents accessing and receiving support from statutory services such as the probation services, DSS or educational and welfare. McEvoy noted that:

'…despite the apparent range of services available to prisoners' families, many of the traditional problems experienced by such families go unmitigated. Further, there appears to be an ironic contradiction for partners of politically motivated prisoners, where an apparently high level of services available is not matched by actual utilisation' (1999: 178).

It is important to note that this research was carried out with partners of politically motivated prisoners and therefore the support from friend and family may not be representative of the prison population as a whole (McWilliams and Spence, 1996). However a number of factors may inhibit prisoners' families from accessing the information and support they need, for example, young people may be reluctant to reveal that a close family member is in prison. They may be worried that their family will be stigmatised as a 'problem/criminal' family (Action for Prisoners, 2003), or fear the professionals will judge them.

Currently, in the UK there is no one professional body responsible for supporting the needs of the families of prisoners although there are many voluntary organisations and individual agencies available to support varying needs amongst these families. Where support is available, families may not choose to engage due to the reasons previously mentioned. Whilst the use of mentoring and counselling may be useful for children who have experienced the trauma of losing a parent through imprisonment such resources are not always readily available without additional referral to other agencies such as Child and Adolescent Mental Heath services. Schools are often not aware of the impact that imprisonment and the surrounding events may have on children's emotional wellbeing, overall development and behaviour and are therefore unlikely to prioritise this as an area for development within the school.

4.5 Think Family

A local authority in the West Midlands has invested in the 'ThinkFamily' project to support the needs of families and children of prisoners and enhance the likelihood of these individuals engaging with professionals and available support. The project primarily aims to reduce re-offending amongst the prison population and to reduce offending amongst their children. Approximately 65% of children who have parents in prison go on to offend themselves (Glover, 2009). There are a number of professionals involved in the project including individuals from a local prison, the Common Assessment Framework team, a local Children's Centre, the voluntary sector, Flying Start and the Educational Psychology Service. A number of actions were agreed and each service took a lead on one or more key strands of the project. Table 1 provides an overview of the key strands to the ThinkFamily project, please see Appendix 1 for a more detailed view of the key strands including aims of the actions and what was involved in carrying out such actions.

The Educational Psychology Service therefore took a lead of three key strands of the project:

1. Gaining children's views and preparing young people for visiting prison
2. Enhancing practitioner awareness of the psychological needs of children who have a family member on prison
3. Providing a framework to support the evaluation of the project as a whole

Key strand	*Lead team*
Development of three booklets for children (early years, primary and secondary).	Educational Psychology Service
Developing the visitors centre- Modelling and supporting interactions with children	Children's centre
Parenting workshops for prisoners	Flying start
CAF training- to all prison staff, probation workers and youth offending teams	CAF team
Family day	Her Majesty's Prison Service
Conference for schools	CAF team
Training to schools and associated services	EPS
Evaluation of the project	EPS

Table 1. An overview of the key strands to the ThinkFamily project

The following section will explore each of these areas in more detail using the Research and Development in Organisations Approach (RADIO) (Knight & Timmins, 1995) as a framework to demonstrate the negotiation of actions.

4.6 The RADIO approach

The RADIO approach was developed by Knight and Timmins (1995) and provides an overall framework for both EPs and EPs in training to conceptualise and manage their school improvement or project based work taking into consideration factors at an organisational level that may hinder or facilitate change. Figure 1 presents a visual representation of the phases of the RADIO approach. Whilst the model is presented in a sequential format, phases often need to be re-visited in the course of an initiative. For example, there may be a need to re-consider the existing formulation of the needs of the organisation or the organisational context and culture, at almost any phase before action can be realistically and meaningfully planned and implemented (Timmins et al, 2003).

4.6.1 Case formulation using the RADIO approach - Clarifying Concerns

- Awareness of Need

Around 65% of children of prisoners go onto become offenders themselves (Glover, 2009). In addition, the previous literature review has demonstrated the possible adverse social and emotional outcomes for children of prisoners affecting not only their own physical, emotional and social wellbeing but also their access to education and success towards their own aspirations. Thus, there is a need to draw upon evidence based interventions at a preventative and systems level; that is working with the children and families of prisoners in addition to working with the prisoners themselves.

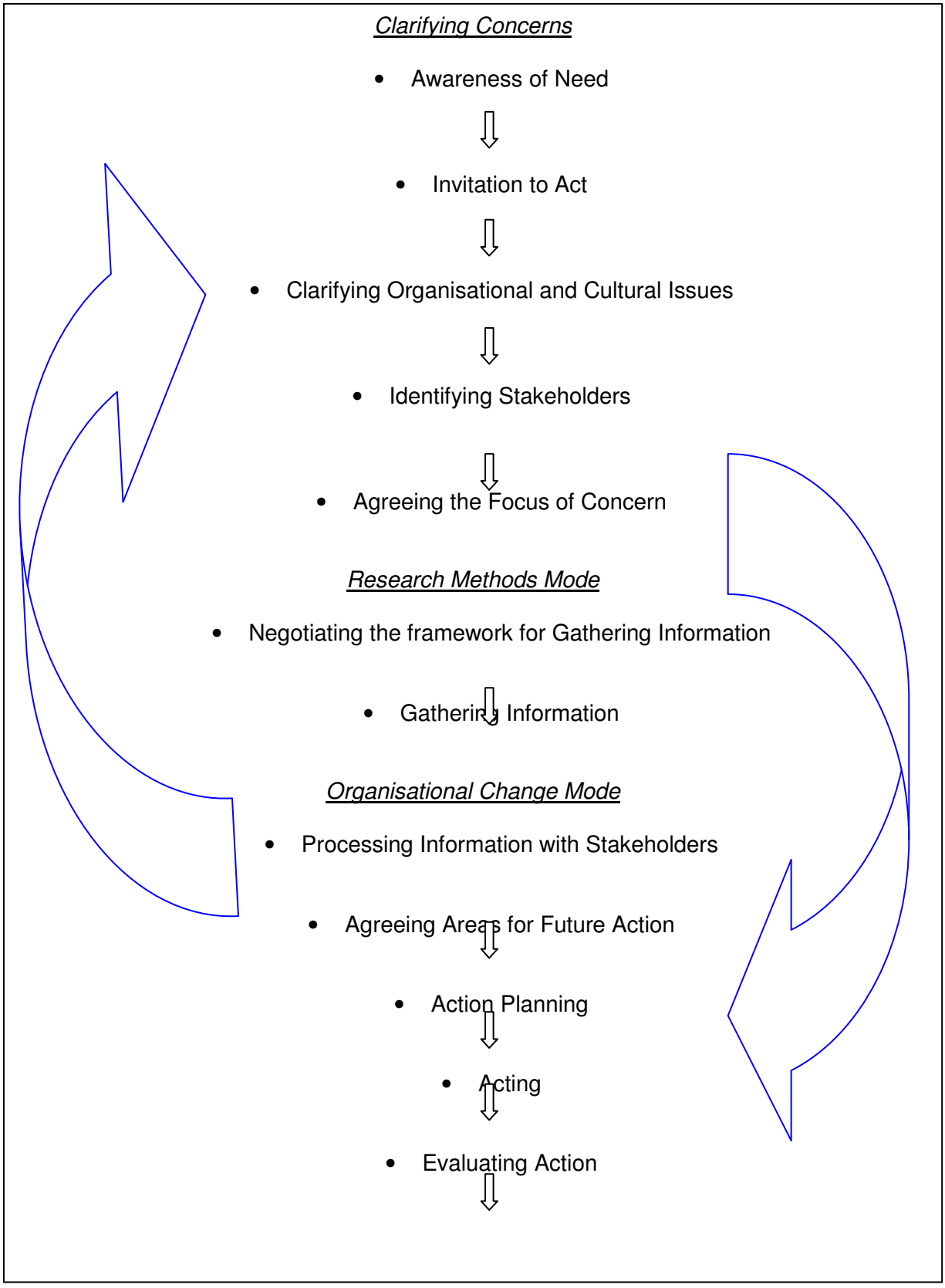


Figure 1, a visual representation of the RADIO approach (Knight and Timmins, 1995).

In order to establish the concerns that prompted this project, a meeting was held between the key stakeholders and the EPS. It was established during this meeting that the project should focus on supporting children, families and prisoners and improving the visiting experience at the local prison for children and their families (helping them to feel more prepared for the visit, reducing anxiety around visiting prison etc). This relates to a much larger overall aim of reducing re-offending amongst prisoners and offending amongst their children. It was hoped that by supporting children and families who were visiting the prison, then the quality of interactions and support for the prisoner would also improve and thus give him more of a reason not to re-offend. Also by supporting families and signposting parents to appropriate agencies, they may be able to access financial and emotional support which may reduce offending amongst children and young people.

- Invitation to Act

The leader of the ThinkFamily project invited the Educational Psychology Service to be part of the project as the group felt that they needed a distinctive psychological perspective to the work that was being planned. In particular they were interested in the psychological impact of a child visiting prison and ways that any negative effects could be reduced.

- Clarifying Organisational and Cultural Issues

One of the organisational issues that we needed to consider when working on this project was the working culture of the different professionals involved. We were bringing a psychological perspective to the project with the emotional wellbeing of children and young people as our

priority, however for the prison officers, their priority was keeping the prisoner secure. Security procedures were therefore somewhat of a barrier to working in the prison. We had to learn the rules, procedures and security processes to aid our joint working with prison staff. In addition, there were also wider cultural issues to consider such as the values and attitudes of prison staff and us as both researchers and members of the project group. These considerations highlight some of the differences between working in the context of a school and a prison and how as applied psychologists we had to adjust our way of working and apply some different theories within psychology to a new and unfamiliar context.

- Identifying Stakeholders

Several key stakeholders were involved in the research coordinating group for the ThinkFamily project. They included representatives from the following agencies; EPS, CAF team, Surestart, a local prison, a local charity for children and families of prisoners and Flying Start (a local agency that aim to support children and their families by working in the community and in local children centres). The views of children, young people, visiting parents and prisoners were also gained throughout the project (see method section) which then impacted on some of the decisions and actions within the research group.

- Agreeing the Focus of Concern

Through several meetings and correspondence, each agency negotiated their role within the project and took a lead on one of more key strands. The EPS agreed to carry out the following actions:

1. Gaining children's views and preparing young people for visiting prison

2. Enhancing practitioner awareness of the psychological needs of children who have a family member on prison

3. Providing a framework to support the evaluation of the project as a whole

1. Gaining children's views and preparing young people for visiting prison

Poehlmann (2005) suggests that children cope better when they are given clear and honest explanations about separations. Without understanding simple facts about their parent's imprisonment, children may experience reduced capacity to process their traumatic loss psychologically, or voice any preferences they may have about contact (Murray, 2003). Material that helps children to learn about imprisonment and understand their own feelings can be formulated in several ways; for example, material that stimulates writing or drawing, or books that children can read (Loucks, 2004). As previously mentioned, there are a range of materials aiming to address the emotional and relational issues that may occur when a family member is sent to prison, however few are in a form suitable for children and young people (Loucks, 2004) and few address visiting prison directly.

2. Enhancing practitioner awareness of the psychological needs of children who have a family member on prison.

Practitioners working in schools may not have an in depth understanding of the possible adverse outcomes that children of prisoners may experience and yet they are in an ideal

position to work with children, young people and families to enhance resilience and engage with families who are experiencing the effects of imprisonment. In particular, family support workers may already have developed a good rapport with some families in the community and parents with partners in prison may feel that they can approach such professionals without feeling stigmatized or judged. Such professionals can then support those families appropriately if they are informed of the needs of children and families of prisoners. EPs are centrally located within the community context where schools form only one setting in which they work (Farrell et al, 2006). EPs therefore have potential access to an array of professionals who they could work with to enhance awareness of the needs of children of prisoners with a particular focus on the psychological mechanisms by which adverse outcomes may occur.

3. Providing a framework to support the evaluation of the project as a whole

The local prison engaged in this project had invested a large amount of money in the ThinkFamily project and had requested an evaluation that demonstrated some of the impact of this financial investment.

4.6.2 Research Methods Mode

- Negotiating the framework for Gathering Information

It was decided within the group to develop three interactive booklets for early years, primary and secondary aged children to help prepare children and young people for their visit to see their relatives in prison. The aim of the booklets was to help children and young people

prepare and reflect on their visit to the prison, in particular focusing upon the emotional impact that the visit might have on them. The booklets were handed out at the visitors centre and it was hoped that parents would go through the booklets with their child whilst waiting. The booklets may then help children and young people to feel less anxious and distract them somewhat from the actual visit and they may also serve as a tool that promotes discussion about the visit between the visiting parent and child. As part of the ThinkFamily project, practitioners from a local children's centre were also available to support children and families at the visitors centre and offered a number of play opportunities and equipment. The staff could also support the use of the booklets. A literature review was completed with a specific emphasis on existing resources and materials for children who were visiting a parent in prison. Another Trainee Educational Psychologist and I designed three draft booklets that detailed activities to help children and young people think about how they might feel about seeing their parent in prison and also what they might like to say to them. Each booklet was differentiated to account for developmental levels and age appropriate activities. We used a range of child development books and resources (Ormiston Children's and Family Trust, 2003) to decide which activities would be most appropriate for early years, primary and secondary aged children.

A qualitative action research method was employed whereby we took the draft booklets to the prison to gain the views of children and young people who were visiting at the time through the use of informal interviews (see Appendix 2 for a copy of the draft booklets). The participants interviewed were chosen due to their presence at the prison on two separate visiting times. Six children aged between 4 and 15 and four parent/carers were interviewed altogether. Semi structured interviews, centred on the draft workbook, were conducted to

elicit the children's and parents'/carers' views of what the final design of the workbooks should be. Table 2 illustrates the open ended questions that were used during the interviews. See Appendix 4 for a timeline of the actions taken as part of the ThinkFamily project.

Questions asked of the children	**Questions asked of the parents/carers**
1. Who are you visiting today? 2. Have you visited him in prison before? 3. How do you feel about coming to the prison to visit him? 4. Here is a booklet that has been made to help children and young people get ready for their first visit into prison. I would really like to get your ideas about it so would you mind having a look at it with me? 5. Do you think this booklet will help children get ready for their first visit into prison? Why? 6. What three things do you like about the booklet? Why? 7. What three things do you think need to be changed about the booklet? Why? 8. Is there anything you think has been missed out of the booklet? 9. Is there anything else you would like to say about the booklet?	1. Do you think there should be something available to prepare children for their first visit to see a family member in prison? 2. What kind of things should be done? 3. Do you think using a booklet would help? 4. Do you think this booklet will help children get ready for their first visit into prison? Why? 5. What three things do you like about the booklet? Why? 6. What three things do you think need to be changed about the booklet? Why? 7. Is there anything you think has been missed out of the booklet? 8. Is there anything else you would like to say about the booklet?

Table 2. Questions used during the semi structured interviews with parents and children.

Themes generated from individual interviews were analysed using thematic analysis (Braun & Clark, 2006).

- Gathering Information

See table 3 for a summary of the themes generated from individual interviews with children and young people visiting the prison:

Theme	Adult and Child/Young Person responses
1. Inclusion of rules/procedures/ prison specific information	• I like that it (the workbook) tells you what happens. • I like it because it's got rules in what you can and can't do. • The (*prison)* specific section would help because it shows what's going to happen.
2.Drawings and pictures	• I like that you can draw. • It needs more signs or pictures so you can circle how you get to the prison, for example the Travel West Midlands sign. • I like the drawing pictures. • I would like a picture of the inside of the prison too. • It would be better if the picture (of the prison) was at the front. • I don't like writing, needs more pictures. • Drawing is good because children like drawing. • Needs more pictures. • I like you can draw a picture of who they are visiting, you could send it to them.
3. Child friendly	• Need more colour to make it interesting for children.

layout	• I want colour- pink, silver and gold. • Bubbles instead of squares would make it more child friendly and cartoon characters to help children understand what they have to do on each page. • The questions about getting there makes it fun.
4. Emotional aspects	• It is a nervous time (going to the prison). • I like the things that you like and don't like (pages in the workbook). • Having the chance to express their feelings (one thing they liked). • Asking about emotions (one thing they liked).
5. Other	• There is learning involved as well as preparing the children. • It's helpful because it teaches you lots of things. • I like the 'About me' because it's interesting.

Table 3: A summary of themes generated from interviews with young people and their parents who were visiting the prison.

A thorough literature review was also completed to gather an in-depth level of knowledge about the psychological and sociological impact of having a parent in prison. This information was then used to design and develop a training package that could be used to enhance the knowledge base for practitioners working in schools and in the community.

4.6.3 Organisational Change Mode

- Processing Information with Stakeholders

The main findings from the literature review were shared with the key stakeholders at a meeting held at the local prison. It was explained that the main findings had led to the design of three booklets. Draft copies of the booklets were then shared with the stakeholders who were each given an opportunity to amend, comment or add to the design within two weeks of the meeting. Interviews with children and young people then took place at the prison and the key themes generated from their feedback were then fed back to the key stakeholders. A final draft of the booklets which had been amended based on the feedback from the interviews was then shared with the group. Again, each individual within the group had an opportunity to amend, comment or add to the design of the booklets. Feedback was taken and the draft design was then negotiated with a graphic designer.

- Agreeing Areas for Future Action

It was agreed that a meeting with a graphic designer would be arranged to discuss the graphics that could be used in the booklets.

It was also agreed that the EPS would design a number of questionnaires to gain the views of children, young people, families of prisoners and prisoners before and after the project in order to measure the impact of the actions taken.

- Acting

1. The themes generated from individual interviews were used to design the final booklets. We worked alongside a graphic designer to refine the design and development of the booklets and produced three final booklets to be used at a local prison.

2. As part of the ThinkFamily project, another Trainee Educational Psychologist and I developed a training package to be delivered to schools. In light of a recent move towards a traded EPS within the local authority in which I work, the schools that will receive the training will be those that express an interest in this population of children and feel that they have a large number of children of prisoners within their school population. However, many parents choose not to tell schools that they have a partner in prison and so some schools who have a need for this training may not have identified that they do and thus may not purchase the training package.

The aims of the session are as follows:

- To discuss the psychological impact on children who have immediate family members in prison
- To discuss the implications that this may have on behaviour and education.
- To look at whole school interventions and strategies to support the needs of children of prisoners
- To look at small group and individual interventions and strategies to support the needs of children of prisoners

- To explore guidelines and resources to help us support the needs of this group of children.

The training will be delivered initially to those schools that have a higher number of children of prisoners in the area with a view to expand this across other areas.

3. In addition, six questionnaires were designed to gain the views of children, visiting parents and family and the prisoners themselves both before the ThinkFamily project had begun and after the agreed actions had been put into place.

The previous literature review highlighted several mechanisms and psychological theories that may account for the adverse outcomes experienced by some children of prisoners including witnessing arrest, parent-child separation, visiting prison, modelling behaviour and stigmatisation and labelling. The actions carried out as part of the ThinkFamily project relate directly to some of those theories. One of the aims of the project was to improve the quality of visits and the visiting experience for children and their families as research has shown that such visits can be particularly traumatic for children and lead to difficult interactions between the prisoner and their child. Where children have been traumatised by separation from a parent who has gone to prison and school are aware of this, strategies such as the use of a key adult (Bomber, 2007) or a mentor can be used to enhance emotional and developmental support. The use of the booklets may also help children to reflect and vocalise how they might be feeling about a family member being in prison. Training for practitioners working with children and families of prisoners will also support the use of individual work and recommended strategies and promote more preventative ways of working with this group of children. The training may also support schools to work more positively to engage with

families of prisoners and address ways in which they may be able to reduce any stigmatization and isolation that these families may be experiencing.

- Evaluating Action

Farrell et al (2006) found that EPs had a vital role in planning, implementing and evaluating initiatives. They also concluded that such research skills were not available elsewhere in local authorities. More recently, there has been an explicit move for EPs towards a role that conceptualises the 'scientific practitioner' (Lane & Corrie, 2006); that is, the application of scientific principles and methods to real world research projects and day to day work within the context of schools and families (Fallon et al, 2010). In the current context of discussions around the development of traded services for EPSs it is becoming ever more important to be able evaluate the impact of our own work on outcomes for children, young people and their families.

In light of these findings within the context of the ThinkFamily project, it was decided that the EPS would take a lead in planning an evaluation of the project as a whole. It was decided to gain the views of our 'customers'; that is children, visiting parents and the prisoners themselves through the use of a pre and post questionnaires. Conducting interviews within the context of a prison is problematic due to access and security procedures and therefore questionnaires seemed a more viable option. Questionnaires were designed and handed to children and visiting parents by prison staff on arrival to the prison. Questionnaires were also sent to the prisoners through prison staff (please see Appendix 3 for examples of the pre and

post questionnaires for children, visiting parents and prisoners). The data from these questionnaires is still being collected as the project will be running until 2011.

4.7 Discussion- The unique contribution of the EP

As the post-data from the questionnaires which were developed to evaluate the outcomes of the project is still being collected, it is difficult to comment of the successes of the overall project in terms of meeting particular outcomes i.e. improving overall visits for children and young people, helping them to feel more prepared for the visit, reducing anxiety around visiting prison etc. However, from being involved in the project it became increasingly apparent that EPs have a unique contribution to add to the field of forensic psychology in helping children to prepare for prison visits. They have a specific knowledge of the psychological mechanisms through which children may be affected by parental imprisonment as well as having a good understanding of typical child development, particularly the development of social and emotional skills. EPs also have training in ways to elicit the views of children and young people in authentic and genuine ways (UN Convention, 1989) and can therefore work alongside children and young people to develop resources to prepare children for visiting prison.

4.7.1 Training and development

One of the distinctive contributions that EPs can make to improving outcomes for children is through the application of psychological theory and research to education and child development. Furthermore a review of the EP role in Scotland (SEED, 2002) identified the

delivery of training at an organisational level as one of the core functions of the EP. EPs are therefore ideally located and skilled to be able to deliver training and workshops around the psychological mechanisms that may be associated with adverse outcomes for children in prison, for example; witnessing arrest (Beckermann, 1998), parental- child separation (Poelmann, 2005; Bowlby, 1969; Bomber, 2007), visiting prison (Comfort, 2003; Grimshaw and King, 2002; Loucks, 2002, Boswell, 2002; Buist, 1997) and stigmatisation (Boswell and Wedge, 2002). EPs can also raise awareness about the types of interventions and strategies that schools could employ at an individual, classroom and whole school level.

4.7.2 Support at the individual level

Some children of prisoners who experience psychological distress may benefit from individual counselling sessions with a mental health professional. Counselling may help them gain insight into their relational and behavioural difficulties and allow professionals to understand the source of anxiety or distress. For example, a child may be feeling angry that the parent engaged in behaviours that led them to incarceration, anxious due to parental separation or depressed and isolated due to stigmatisation (Shillington & Edwards, 2008). EPs who have specialist skills in the area of counselling could be used in this capacity to support the needs of children of prisoners through direct one to one or family based therapeutic work.

In addition, the use of a mentoring programme may be beneficial for children of prisoners. Children of prisoners may benefit from the explicit creation of adult and or peer mentor relationships in school, mentors can assist children of prisoners to develop relationships that foster attitudes of trust, support and acceptance (Edwards et al, 2007). The idea of forming an

explicit, unconditional relationship with a trusting adult also links with attachment theory. Children of prisoners may have lost their secure attachment figure when there parent went to prison or may not have formed a secure attachment with a family member if life before prison had been chaotic, Bomber (2007) suggests that the use of a key adult is essential for children who have experienced trauma and loss. The key adult in the classroom is emotionally available for the child at key times during the day and can provide them with unconditional support that fosters a sense of worth and meaning. Bowlby, (1969) argues that humans subconsciously form an internal working model which represents adults and significant others in our lives. If we learn through a secure attachment that adults are consistent predictable and reliable then we will learn that we are worthy of love and attention. However, if we learn that adults are unreliable, unpredictable and inconsistent then we may also learn that we are worthless and not loveable. It is this subconscious representation of our relationship with our primary caregivers that is later mirrored in other relationships with adults and peers. Positive secure relationships with an adult may therefore help the child to adjust their own internal working model and build positive relationships with others.

Whilst the use of a mentor may provide a consistent relationship for these children, such support needs to be planned and considered carefully in light of the relevant research and psychological theory (Bocknek et al, 2009). EPs could therefore support the development of a mentoring programme specifically for the children and young people of prisoners and work indirectly with schools and professionals to support the needs of these children.

4.7.3 Support within the classroom and across the school

Parents of prisoners often emphasize how difficult it is to talk with schools (Ormiston, 2007). Miller (2003) discusses the idea that EPs often create a temporary overlapping system between the school and the family which may assist in opening new dialogues that lead to further actions and support for the family. Using a consultation model, EPs could be used to support the initial interactions and relationships between families of prisoners and schools. In addition from a whole school perspective, EPs can work with schools to further develop their capacity to support parents and pupils by:

- Increasing the visibility of issues facing prisoners' families for students, staff and carers- through posters and leaflets at information points, and books and other resources being available throughout school. (Ormiston, 2007).
- Ensuring carers feel more able to ask for support through making school procedures better understood, having relevant information and publicity on confidential support available to families (Ormiston, 2007; Shillington & Edwards, 2008).
- Providing information and national specialist support available to families, or referring them to the appropriate agencies (Ormiston, 2007).
- Looking at how children of prisoners can be supported through school policies and a whole-school approach and being prepared to include parents who are in prison wherever possible (Ormiston, 2007).
- Increasing awareness in the classroom that children affected can be more appropriately supported- and accurate information about prison life be made available for all children (Ormiston, 2007).

4.7.4 Application of research methods

EPs also have an in depth knowledge of research methods and frameworks that can be applied to real world research and therefore have skills to design, implement and evaluate project work like the ThinkFamily project which in this case was a distinctive contribution of the EP. In addition, the current research that looks at attachment and imprisonment is predominately based on a female population. EPs as applied psychologists could carry out further research in this area to support the generalisation of findings from attachment theory to paternal imprisonment. Furthermore, we know that children and young people are more likely to go on to offend in their later childhood or early adulthood but we do not know the psychosocial mechanisms that support this correlation. EPs could carry out research with children and young people of prisoners who may have already gone on to offend to explore some of the reasons why this has happened and therefore design interventions at a preventative level by working with this vulnerable group of children. EPs can therefore support project work in this area and also carry out new research that may contribute to the existing knowledge base of working with children of prisoners.

The existing literature and research around the children of prisoners is not as vast or in-depth as our knowledge of other vulnerable groups of children e.g. looked after children. However, the existing research does suggests that this population of children are a highly vulnerable group who are likely to experience a range of adverse outcomes through a number of psychological and or social mechanisms. The ThinkFamily project has demonstrated the value of multi agency work and the unique contribution that EPs as applied psychologist can make

to this area of work. Arguably, these are skills that psychologists can apply across a number of contexts and this supports the role of the EP as a more generic applied psychologist.

4.8 Critical reflections

Whilst there have been many positive outcomes from this project, there were also some difficulties working with this population of children that should be considered by other professionals conducting research in this area. One of the biggest barriers to working with children of prisoners is identification and access. There are no mechanisms currently in place to monitor how many children are affected by imprisonment and so schools do not always know if they have children in their school who have been affected by parental imprisonment. Schools may not see training about this population as a priority and getting resources and support to these children and their families can therefore be very difficult. Moreover, families may choose not to tell professionals about their circumstances which then further restricts opportunities for support. Gaining children's views is also difficult, we interviewed children in the waiting hall before they went into visit their parents and whilst they were fully informed about the research and consent was gained from the child and their parents, there are still a number of methodological and ethical issues to consider, e.g. the lack of privacy, perceived pressure to participate, gaining views at a time when children are already highly anxious about their visit etc.

In addition, the security procedures within the prison system may further restrict the nature of work and in this case the availability of resources. The booklets that were developed to support prison visits for children were only available from the prison to be used in the prison

during that time. This is because the prison would not accept paper from outside that could be transferred to prisoners as some papers can be soaked in illegal substances before the visit. A further development of this project may then be to develop more generic booklets that can be used by parents or in schools to help prepare children for their visit to prison. Professionals who want to visit the prison will need to undergo further security checks and procedures beforehand which can sometimes take a number of weeks. Children and families of prisoners are therefore a difficult population to reach and professionals need to consider this carefully before conducting project work or research.

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4.9 APPENDICES

Appendix 1: A table to show the key strands of the ThinkFamily project, including aims, actions involved and who took the lead for each strand.

Appendix 2: A draft copy of the early years booklet designed to support children and young people who were visiting a local prison.

Appendix 3: Pre intervention and post intervention questionnaires sent to children and young people, prisoners and visiting parents.

Appendix 4: Timeline of actions taken as part of the ThinkFamily project.

Appendix 1: A table to show the key strands of the ThinkFamily project,

Key strands	**Aims**	**What was involved?**	**Who lead on this strand of the project?**
Development of three booklets for children (early years, primary and secondary).	1. To help children prepare for the psychological impact that visiting a family member in prison might have on them. 2. To help children prepare for the actual visit and to be aware of security procedures they may have to go through. 3. To promote discussions between children and their carers about a family member being in prison.	- Literature review around existing resources and psychological impacts of having a family member in prison. - Gaining children's views around what they think should go into the booklets. - Writing booklets and differentiating language for different age groups. - Collaborating with a graphic designer around the design and print of the booklets.	Educational Psychology Service
Developing the visitors centre- Modelling and supporting interactions with children	1. To have children centre staff on site twice a week to support interactions with children and families. 2. For staff to be able to signpost to other outside agencies and support for families. 3. To reduce feelings of anxiety and worry for children. 4. To help prepare the children for their visit. 5. To model useful play skills and dialogue to use with children to parents.	- Two members of staff from a local children's centre placed in the visitors centre for two sessions per week. - Purchase of play equipment and a child friendly environment in the visitors centre.	Children's centre manager and staff

Parenting workshops for prisoners	1. To engage with prisoners about the importance of parenting 2. To develop skills that allow prisoners to maintain effective relationships with their children when in prison and when released. 3. To reduce the likelihood of a prisoner re-offending. 4. To prepare prisoners for the reintegration into their families and the community.	- Meeting with the prisoners on a regular basis - Delivering a parenting workshop - Building rapport with prisoners - Discussing opportunities to generalise and rehearse newly acquired skills with their children.	Flying start
CAF training- to all prison staff, probation workers and youth offending teams	1. For all staff working with prisoners to be aware of the CAF process 2. To enhance awareness of prisoners families their needs and possible support they are likely to require. 3. To use the pre- CAF questionnaire with all prisoners who enter the prison	- Training all prison staff, probation officers and drug agencies around the use of the CAF - Designing and implementing a pre CAF check list specifically for prisoners and their families.	Birmingham's CAF team
Family day	1. To give prisoners who are just about to be	- Prisoners who were due to be released	HMP Birmingham and

	released the opportunity to interact with their children in an informal way. 2. To allow children to become more familiar with their parents and to feel more comfortable about their release. 3. To promote and support the importance of interacting with your children and family.	soon were given the opportunity to invite their families to visit and were able to interact with their children in an informal way, that is they were not restricted to sitting on their chairs. - Resources were provided such as toys and books to support interactions between parents and children.	Children's centre staff
Conference for schools	1. To promote awareness of this vulnerable group of children in schools. 2. To help school staff understand some of the issues families of prisoners might experience and what behaviours we might see in a child as a result. 3. To promote some of the work that has been achieved through the think family project	- Inviting schools to the conference - Presenting information around the process of visiting someone in prison - Discussing some of the impact that having a family member in prison might have on children and their families.	Educational Psychology Service Children Centre staff HMP Birmingham Birmingham's CAF team Halow Parenting support
Training to schools	1. To discuss the psychological impact on children who have immediate family members in prison 2. To discuss the implications that this may have on behaviour and education. 3. To look at whole school interventions and strategies to support the needs of children of prisoners 4. To look at small group and individual interventions and strategies to support the needs of children of prisoners 5. To explore guidelines and resources to help us support the needs of this group of children.	- Literature review looking in detail into the psychological and sociological impacts that having a family member in prison might have on the child and implications on their emotional, social wellbeing and academic achievement. - Preparing training session - Peer review - Looking at prison statistics to see which areas would benefit from the training - Delivering to schools.	Educational Psychology Service
Evaluation of the	1. To gain views of parents, prisoners and young people	- Designed three questionnaires for parents,	Educational Psychology

project.	around the impact of the ThinkFamily project.	prisoners and young people to gain views about the prison and visiting before the project began. -Designed three questionnaires for parents, prisoners and young people to gain views about the prison and visiting after agreed actions had been carried out.	Service

Appendix 2: A draft copy of the early years booklet designed to support children and young people who were visiting a local prison.

Visiting the prison

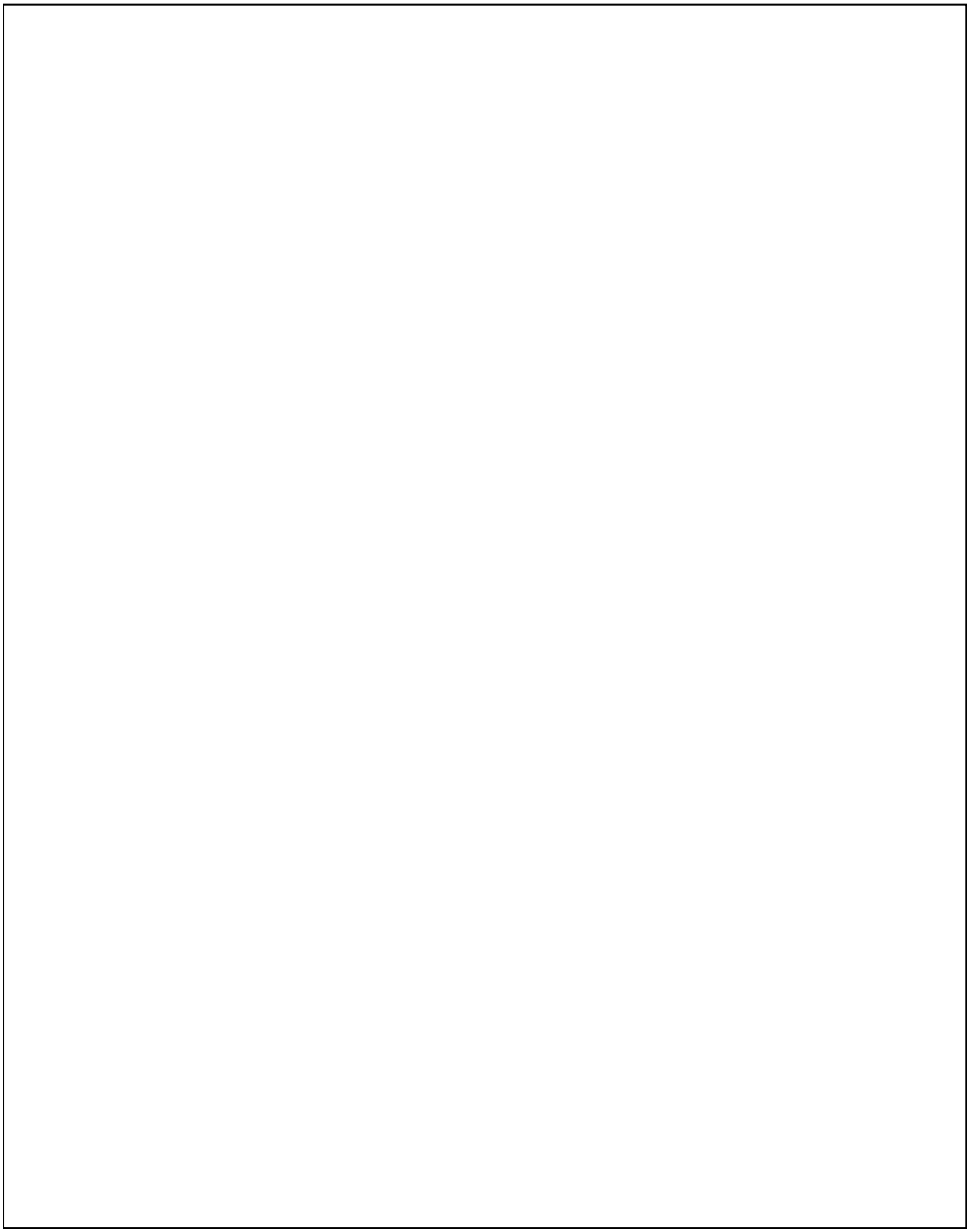
My workbook

This is me…

Name: ……
Age:……

The person I am visiting is called ……

He looks like…



This is how I feel about him being in prison…

Happy	Sad	Worried
Upset	Angry	
……		

Winson Green

This is what it looks like from the outside

Visiting Winson Green

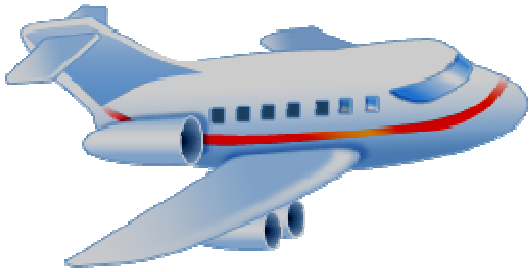
- When you first arrive, the adult that you are with will sign a register for you both.
- Next you will go through to the security section. You will have to put your bags though a special machine.
- A lady will then search you by patting down on your clothes just to check that there is nothing sharp that you are carrying into the prison as sharp items could be used to hurt somebody.
- You will then go upstairs where you will wait until you get called to go into the visiting room.
- If you do have any bags with you, you will need to put them in a locker which is in the waiting room.
- You can take this booklet in to the visit with you, you can also take loose change for the drinks machines.
- Sometimes there are dogs who might sniff you and the adults you are with, this is part of the security at the prison. You can stand on your own or with an adult if you like.
- You can then go through to the visiting hall.

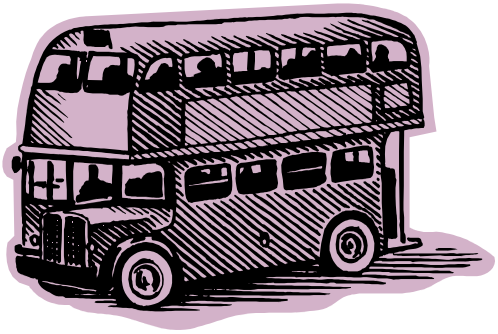
Is there anything else I want to know about visiting him?

Getting there

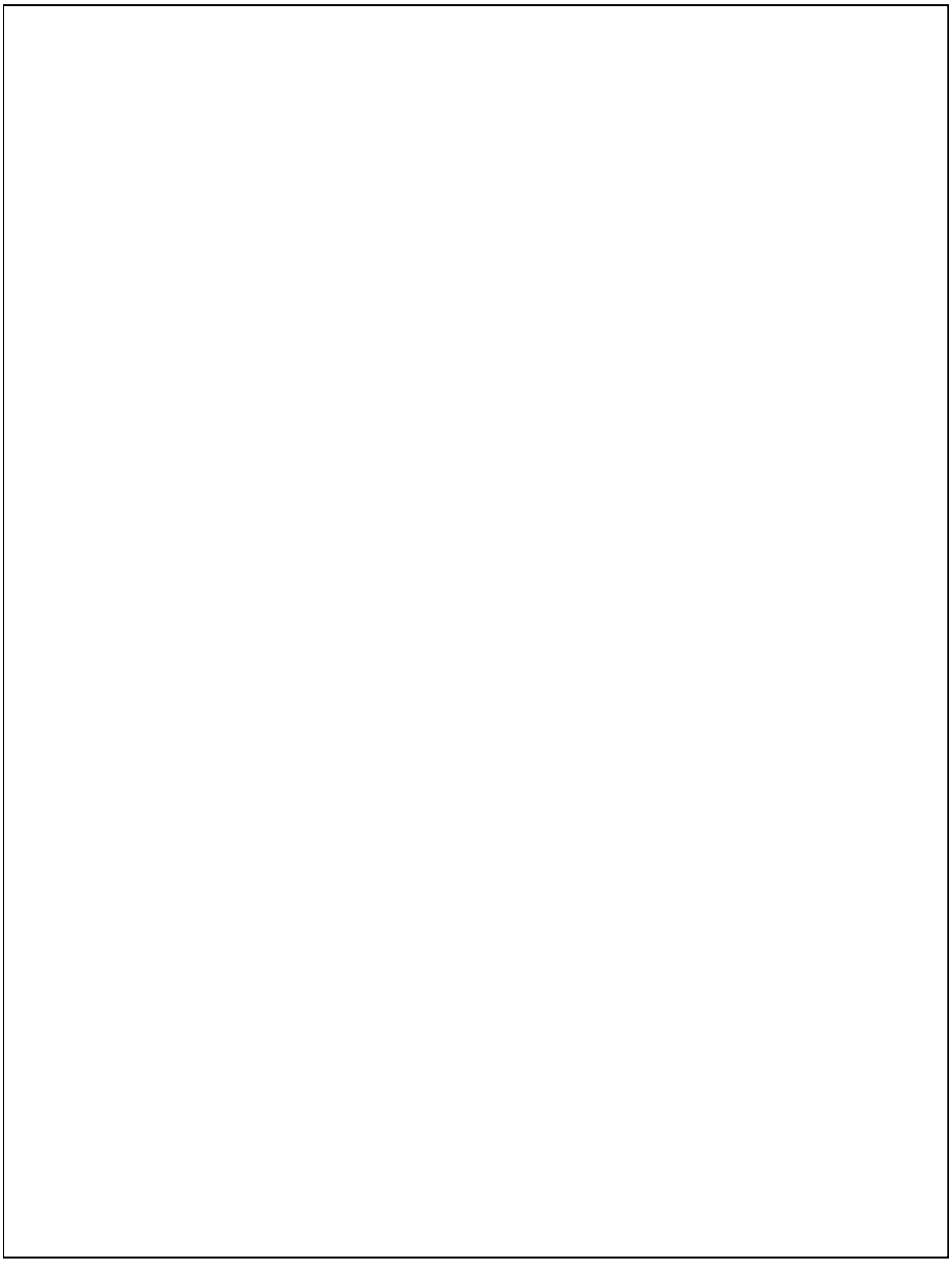
I am going to visit him with……..

I am getting there by…

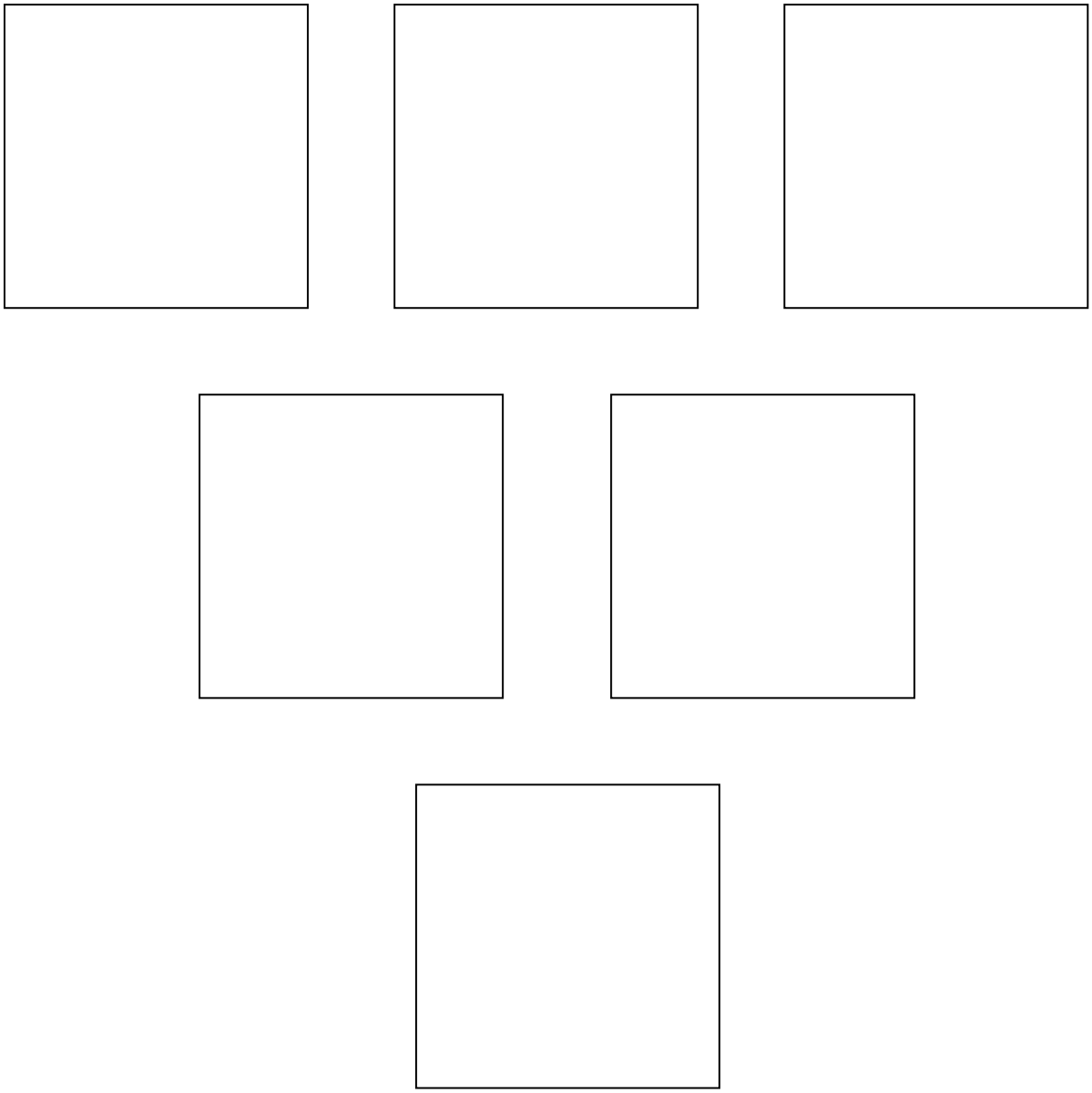




When I see him, I want to tell him about…..



This is how I felt after seeing him…



The best part was…

……

……

……

……

The worst part was…

……

……

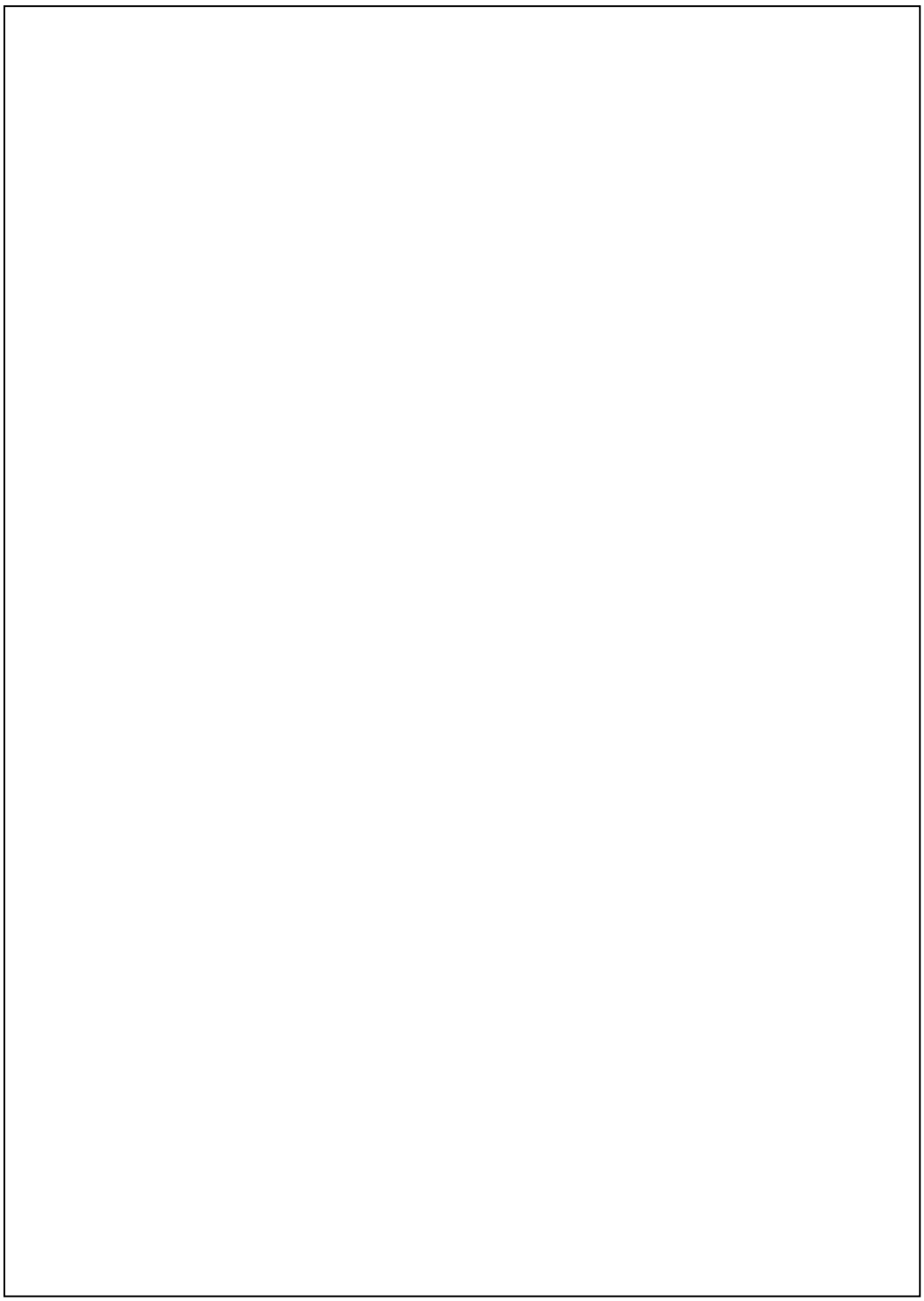
……

……

I am going to speak to him again on……

Is there anything else you would like to draw or write about your visit today?

Would you like to draw a picture or write a story to give to the person you are visiting today?



Need to talk?
Call ChildLine

Calls are free and confidential

Produced by Birmingham's Educational Psychology Service

Appendix 3-Questionnaires sent to children and young people, visiting parents and prisoners before the ThinkFamily project began.

We are currently working on a project that aims to improve visits to prison for children, parents and families. As part of the initial information gathering process we would like

Think family project- Gaining the prisoner's views

to hear your views. You do not need to put your names on the questionnaire so nobody will be able to identify your views. Could you please take a few minutes to read and complete the following questionnaire?

1. Do you have children? Yes/No

2. Do your children/other children come to visit you in prison? Yes/No

3. How old are the children that come to visit you?

Child 1……. Years
Child 2……..Years
Child 3……..Years

4. Approximately, how often do they come to visit you?

Weekly	
Fortnightly	
Monthly	
Every 2 months	
Every 6 months	
Yearly	
Less than once per year	

5. How prepared did you feel that your children were on their last visit to the prison? (Please circle a response per child and label the circle with child 1, child 2 etc).

0----------1----------2----------3----------4----------5
Not very prepared Very prepared

6. How would you rate the quality of the last visit you had with your children? (Please circle a response per child and label the circle with child 1, child 2 etc).

0----------1----------2----------3----------4----------5
Very poor Very Good

7. How engaged with you did you feel your children were on their last visit? (Please circle a response per child and label the circle with child 1, child 2 etc).

0----------1----------2----------3----------4----------5
Not very engaged Very engaged

Please turn over…

8. How would you describe your children's emotional states when they come to visit?

Child 1
……
……

Child 2
……
……

Child 3
……
……

Thank you for your time, could you please return the questionnaire to……

Think family project- Gaining visiting parent's views

Birmingham City Council and HMP Birmingham are currently working on a project that aims to improve visits to prison for children, parents and families. As part of the initial information gathering process we would like to hear your views. You do not need to put your names on the questionnaire so nobody will be able to identify your views. Could you please take a few minutes to read and complete the following questionnaire?

1. Do you bring your children to visit the prison? Yes/No
(if yes, please go to q.3, if no, please complete q.2 and q.3 only)

2. If no, is there a specific reason for this? Please state
……
……
……

3. How old are your children?

Child 1……. Years
Child 2……..Years
Child 3……..Years

4. Approximately, how often do you and your children visit the prison?

Weekly	
Fortnightly	
Monthly	
Every 2 months	
Every 6 months	
Yearly	
Less than once per year	

5. How prepared for the visit did you feel your children were on their last visit to the prison? (Please circle a response per child and label the circle with child 1, child 2 etc).

0----------1----------2----------3----------4----------5

Not very prepared Very prepared

6. How would you rate the quality of the last visit your partner had with your children? (Please circle a response per child and label the circle with child 1, child 2 etc).

0----------1----------2----------3----------4----------5

Very poor Very Good

7.How engaged did you feel your children were with the prisoner on their last visit? (Please circle a response per child and label the circle with child 1, child 2 etc).

0----------1----------2----------3----------4----------5

Not very engaged Very engaged

8. How would you describe your children's emotional states on their last visit?

Child 1
……
……

Child 2
……
……

Child 3
……
……

9. What three things could the prison do to improve your child/children's visit to the prison?

1……
……..
2……
……..
3……
……..

Thank you for your time, could you please return the questionnaire to……

Think family project- Gaining young people's views

We are interested in gaining your views about your visit to HMP Birmingham today. You do not need to put your names on the questionnaire so nobody will be able to identify your views. If you could take a few minutes to read through these questions and answer them as honestly as you can we would be really grateful.

1. How old are you?.....

2. Did you talk to someone about what would happen on your visit today? (Please circle)
Yes/ No

3. Did you know that you might; (please tick the appropriate box)

	Yes	**No**
a) Have to be searched?		
b) Have to wait a long time?		
c) Have to leave all your things with security?		

4. What did you do at the visiting centre today?

……

……

……

5. What did you do in the visiting hall today?

……

……

……

6. How did you feel when you were waiting in the visiting hall today? (Please tick the appropriate box or boxes)

Happy	
Sad	
Nervous	
Worried	
Calm	
Angry	
Upset	
Safe	
Other ……	

Please turn over….

7. How much did you enjoy your visit to HMP Birmingham today? (Please circle whereabouts on the line you feel you might be)

0----------1----------2----------3----------4----------5

Did not enjoy my visit at all

Really enjoyed my visit today

Thank you for your time. When you have finished please put the questionnaire in the post box in the…….

Questionnaires sent to children and young people, visiting parents and prisoners after the ThinkFamily project began.

Think family project- Gaining your views (prisoners)

You may recall completing a questionnaire like this some time ago. We have since been working on a number of ways to improve visits to prison for children, parents and families.

As part of our review and evaluation, we would like to hear your views even if you did not complete the first questionnaire. You do not need to put your names on the questionnaire so nobody will be able to identify your views. Could you please take a few minutes to read and complete the following questionnaire?

1. Do your children come to visit you in prison? Yes/No
(if yes, please go to q.3, if no, please complete q.2 and q.3 only)

2. If no, is there a specific reason for this? Please state……
……
……

3. How old are your children?

Child 1……. Years
Child 2……..Years
Child 3……..Years

4. Approximately, how often do they come to visit you?

Weekly	
Every fortnight	
Monthly	
Every couple of months	
Every 6 months	
Yearly	
Less than once per year	

5. Did your child/children engage with the children's centre staff and activities in the play area of the visiting centre today? (please circle a response) Yes/No

6. If yes, how do you think this improved your child's experience of visiting the prison today?

……
……
……
……

7. Was your child given a 'visiting prison' booklet today? (please circle a response) Yes/No

8. If yes, did your child/ children complete the 'visiting prison' booklets today? (please circle a response) Yes/No

9. On a scale of 1-5, how useful was the booklet in preparing your child/children for their prison visit today?

Not very useful Very useful

0----------1----------2----------3----------4----------5

10. How engaged did you feel your children were with you on their visit today? Please circle more than one rating for each child that came to visit you.

0----------1----------2----------3----------4----------5

Not very engaged Very engaged

11. Could you describe your perceptions of your children's emotional states on their visit today?

Child 1
……
……

Child 2
……
……

Child 3
……
……

12. Have you noticed any difference in the quality of visits with your children in the last months? If yes, could you give details.
……
……
……
……

Thank you for your time, could you please return the questionnaire to Ade Steventon.

Think family project- Gaining your views as visiting parents

You may recall completing a questionnaire like this some time ago. We have since been working on a number of ways to improve visits to prison for children, parents and families.

As part of our review and evaluation, we would like to hear your views even if you did not complete the first questionnaire. You do not need to put your names on the questionnaire so nobody will be able to identify your views. Could you please take a few minutes to read and complete the following questionnaire?

1. Do you bring your children to visit the prison? Yes/No
(if yes, please go to q.3, if no, please complete q.2 and q.3 only)

2. If no, is there a specific reason for this? Please state……
……
……

3. How old are your children?

Child 1……. Years
Child 2……..Years
Child 3……..Years

4. Approximately, how often do they come to visit you?

Weekly	
Every fortnight	
Monthly	
Every couple of months	
Every 6 months	
Yearly	
Less than once per year	

5. Did your child/children engage with the children's centre staff and activities in the play area of the visiting centre today? (please circle a response) Yes/No

6. If yes, how do you think this improved your child's experience of visiting the prison today?

……
……
……
……

7. Did you engage with the children's centre staff today? If yes, did you find it useful?

……
……
……
……

8. Was your child given a ‘visiting prison’ booklet today? (please circle a response) Yes/No

9. If yes, did your child/ children complete the ‘visiting prison’ booklets today? (please circle a response) Yes/No

10. On a scale of 1-5, how useful was the booklet in preparing your child/children for their prison visit today?

Not very useful Very useful

0----------1----------2----------3----------4----------5

11. How engaged did you feel your children were with the prisoner on their visit today? Please circle more than one rating for each child that came to visit you.

0----------1----------2----------3----------4----------5

Not very engaged Very engaged

12. Could you describe your perceptions of your children’s emotional states on their visit today?

Child 1
……
……

Child 2
……
……

Child 3
……
……

Thank you for your time, could you please return the questionnaire to
……
……

Visiting HMP Birmingham

Young people's views….

You may have already completed a questionnaire like this before, however we have made a few changes to the prison since then and we wondered if you could fill this questionnaire in again.

You do not need to put your names on the questionnaire so nobody will be able to identify your views. If you could take a few minutes to read through these questions and answer them as honestly as you can we would be really grateful.

1. How old are you?.....

2. Were you given a booklet about visiting prison today from the staff at the visiting centre? (please circle a response) Yes/ No

3. Did you complete the booklets about visiting prison today? (please circle a response)

Yes/No

(If no go to questions 6)

4. Did someone help you to complete the booklets? (please circle a response)
Yes, ……helped me/ No I completed them alone

5. Do you feel that you learnt something new from the booklets about visiting prison today? (Please circle whereabouts on the line you feel you might be)

0----------1----------2----------3----------4----------5

I did not learn anything new

I learnt lots of new things

6. Did you know that you might; (please tick the appropriate box)

	Yes	No
a) Have to be searched?		
b) Have to wait a long time?		
c) Have to leave all your things with security?		

7. What did you do at the visiting centre today?

……
……
……

8. How did you feel when you were waiting in the visiting hall today? (Please tick the appropriate box or boxes)

Happy	
Sad	
Nervous	
Worried	
Calm	
Angry	
Upset	
Safe	
Other, ……	

9. How much did you enjoy your visit to HMP Birmingham today? (Please circle where about on the circle you feel you might be)

0----------1----------2----------3----------4----------5

Did not enjoy my visit at all

Really enjoyed my visit today

Thank you for your time, When you have finished just pop the questionnaire in the post box in the…….

Appendix 4- Timeline of actions taken during the ThinkFamily project

Time	**Action**
January 2010	Initial meeting to discuss the role of EPs in the ThinkFamily Project.
February	Designed questionnaires and handed out to children, parents and prisoners.
February- March 2010	Literature review, looking at existing resources and designing draft booklets.
March 2010	Interview with children and their carers at the prison.
March- April 2010	Analysing data from questionnaires and interviews.
May 2010	Met with graphic designer to discuss the booklets.
June 2010	Final booklets were designed and printed.
June 2010	Meeting with the group to look at the booklets and discuss data collected to date.
September- 2010	Handed post questionnaires out to children, parents and prisoners.
November 2010	Collected and analysed data.
November 2010	Presented project to EPs at a service day.
November 2010- January 2010	Designed training package for professionals working with children and families of prisoners.
December 2010- January 2011	Prepared for the ThinkFamily conference.
February 2011	ThinkFamily conference
March-May 2011	Refining training package
June 2011	Delivering training to professionals working with children of prisoners

CHAPTER 5- PROFESSIONAL PRACTICE REPORT 4

5.1 Title

Working with children who have an acquired brain injury (ABI): How can Educational Psychologists support the reintegration of children who have an ABI from rehabilitation back to full time education?

5.2 Abstract

This small scale research study involved interviewing eight professionals from two different settings who work directly with children who have had an acquired brain injury (ABI). The first is a specialised national rehabilitation centre and the second is a nationally recognised children's hospital that specialises in neurology and brain injury. Two educational psychologists (EPs), a speech and language therapist, an occupational therapist, a clinical psychologist and the head teacher of a medical pupil referral unit attached to the centre were interviewed from the specialised rehabilitation centre. A paediatric neuropsychologist and a clinical psychologist were interviewed from the children's hospital. The aim of the interviews was to explore the rehabilitation process for children who have had an ABI with a particular focus on how educational psychologists from the local authority might support this process. Semi structured interviews were used; the interviews were transcribed and analysed using thematic analysis (Braun & Clarke, 2006). Several key themes were generated from the data. With regards to the role of the EP in supporting the rehabilitation process for children who have had an ABI, the following sub themes were identified: attending discharge meetings, translating medical reports, training school staff about the needs of children

with an ABI, raising awareness and monitoring the progress of children with an ABI, liaising with rehabilitation teams, knowledge of local provisions, coordinating and facilitating meetings and providing a further resource in the community after children have been discharged from specialised rehabilitation. It was thought that educational psychology services (EPSs) would benefit from having at least one EP who specialised in neuropsychology and the implications of an ABI and that the initial doctoral training course for EPs should include a module on typical and atypical brain development. Key actions are recommended for EPs and EPSs in order to develop their capacity to meet the needs of children who have had an ABI (mild, moderate or severe) and the needs of their families.

5.3 What is an ABI?

Acquired brain injury (ABI) is defined as damage to living brain tissue which causes impairment of normal brain function and can be caused by:

- internal events such as a stroke; haemorrhage; aneurysm; virus/infections such as meningitis; hypoxic (oxygen) starvation; events which might be the result of a cardiac arrest; drug abuse; near drowning; brain tumours or neurological disease; and/or,
- external events such as a road traffic accident; domestic/industrial accidents and falls; sports recreational injuries and assault (Rehab UK, 2002).

The term ABI is often used as an umbrella term that encompasses all types of brain injuries. The term traumatic brain injury (TBI) is used to refer to damage caused by an external event, typically a road accident or fall. External events are the most common cause of brain injury (Rehab UK, 2002) and a major source of childhood injury in the UK (Fletcher et al, 1995). The term ABI will be used throughout this essay as a term that encompasses both internal and external causes of brain injury.

The severity of the brain injury is often measured by the depth and duration of coma and the period of post traumatic amnesia (PTA) after the event. A person who remains unconscious for over six hours is likely to have sustained a severe brain injury. Loss of consciousness for fifteen minutes or less suggests a mild brain injury and the period between the two suggests a moderate brain injury. The process of recovery from a coma is gradual; it is likely that an individual will slowly begin to emerge from a coma and become increasingly responsive to their environment eventually reaching full consciousness. The depth of coma is measured using the Glasgow Coma Scale (GCS) (Teasdale & Jennett, 1974, National Institute of Clinical Excellence, 2007) which is usually taken upon hospital admission and periodically thereafter to determine the extent of brain injury (see table 1 for definitions of mild, moderate and severe brain injury using the GCS). The scale has three categories, eye opening, best motor response and verbal response. Each of these categorise contributes towards a final score. The lower the score on admission, the more severe the brain injury is thought to be.

Amnesia refers to memory loss. PTA is a particular kind of memory loss associated with a brain injury that lasts for a specific amount of time. The duration of PTA is considered to be the best indicator of long term effects following a brain injury (Rehab UK, 2002). It is widely acknowledged that there does generally appear to be a correlation between the severity of the ABI and the persistence and extent of subsequent difficulties (Rehab UK, 2002). The more severe the injury, the more likely it is that the individual will experience significant physical and long term emotional and cognitive problems (Rehab UK, 2002), although there are likely to be individual differences in the eventual outcome.

Severity	PTA	Loss of consciousness/coma
Mild	Less than 1 hour	Less than fifteen mins
Moderate	1- 24 hours	15mins- 6 hours
Severe	Greater than 24 hours	Greater than 6 hours

Table 1: Taken from The Brain Injury Handbook (Rehab UK, 2002).

5.3.1 Incidence

There is no official consensus for the number of children who have had an ABI, although recent data suggests that, every year, approximately 280 in every 100,000 under-14-year-olds suffer from a traumatic head injury in addition to non traumatic head injuries (Rees & Skidmore, 2008). Advances in medical practice mean that more children are surviving from head injuries caused by both traumatic accidents and oxygen starvation. It is estimated that approximately 3% of children are affected by ABI (including traumatic and injury caused internally) each year and therefore the proportion of pupils in schools who have been affected is greater than this (Trust-ED, 2006, 2007). It is essential then that schools develop their capacity for supporting the learning of these children and young people. A vital part of this work will be the dissemination of information and expertise on a nationwide basis, along with the provision of ongoing support services for families and professionals (Trust-Ed, 2006, 2007).

5.3.2 Age at injury and the course of recovery

The outcomes of an ABI will vary according to the age at which the child sustained the injury. Children's brains are rapidly enlarging in size and complexity throughout their development through to early adulthood. Some areas of the brain may be fully functional at an early age (e.g. the occipital lobes) although other areas (e.g. the distal areas of the temporal lobes) only fully myelinated in adolescence and early adulthood (British Psychological Society, 2004).There appears to be a common misconception that children recover better than adults from an ABI due to the idea that cerebral

plasticity will allow other areas of the brain to take over the learning of new skills. Plasticity for development is what supports the young brain in acquiring new functions, skills and knowledge. After damage to the immature brain, plasticity for recovery which underlies the reorganization of functions lost or disrupted from an injury co-exists with plasticity for development and both contribute to long term cognitive outcomes (Dennis & Levin, 2004). Unlike the adult brain then, childhood head injury exists against an ongoing background of cognitive development and research suggests that ABI has a more deleterious effect on the cognitive skills of young children. Typically children injured before the age of seven or eight fail to demonstrate expected recovery patterns and tend to exhibit more long term cognitive impairment in comparison to older children and adults (Anderson & Moore, 1995; Verger et al, 2000). Damage to areas of the brain that have already developed tends to become immediately obvious after an ABI through the loss of specific skills. Where damage occurs to developing parts of the brain, emerging skills and the integration of new skills into existing knowledge may be diminished (British Psychological Society, 2004). Further difficulties may therefore become apparent as an individual becomes older when new emerging skills begin to develop. In essence then, the recovery of functions is easier for an injured mature brain than is the learning of new skills for the first time for an injured immature brain.

5.4 Effects of ABI: Cognitive, behavioural, social and emotional

The effects of an ABI will be dependant upon the nature and severity of the injury and may include the following: physical difficulties such as headaches and fatigue, post traumatic epilepsy, cognitive difficulties such as poor concentration, a slower speed of thought, language processing, speech and memory, personality change, loss of emotional control, anxiety, depression, egocentricity, disinhibition and impulsivity, loss of initiative, irritability, impatience and reduced tolerance and possible changes in sexuality (British Psychological Society, 2004). It is important to understand the academic difficulties experienced by students after an ABI in order to develop appropriate targeted interventions that maximize long term adjustment and outcomes for children.

The impact of an ABI on the development of cognitive skills can be far ranging from discrete subtle difficulties that may go undetected in the classroom to severe

impairments that impact on an individual's ability to carry out day to day life tasks (DfEE, 2001). One area that children have persistently demonstrated deficits in after an ABI is working memory, a construct referring to the ability to relate old information to new incoming information (Roncadin et al, 2004) by holding chunks of information before processing them to a long term memory system (Baddeley & Hitch, 1974). The development of working memory impacts on our ability to follow basic instructions in all contexts and is a core cognitive resource that is essential to learning. Working memory inefficiency is thought to constrain children's ability for cognitive processing and to contribute to learning difficulties (Hulme & Roodenrys, 1995). Impaired verbal working memory also has widespread consequences for the development of pragmatics, discourse, sentence comprehension and inference, skills which are important for the overall development of language and literacy (Hulme & Roodenrys, 1995).

It is thought that the functions of working memory can be separated into two brain regions, the posterior brain regions which are responsible for the storage of information and the frontal lobe regions which are responsible for the maintenance and monitoring of information. In more than two thirds of severe head injuries, frontal lobes are damaged (Mendelsohn et al, 1992) and it is therefore likely that some of the functions that facilitate working memory will be impaired. The extent of the impairment will depend of the severity of injury; consistently children with severe ABI will exhibit poorer memory than those with mild head injury. This applies to working memory and other types of memory such as prospective memory (McCauley & Levin, 2004).

Looking more widely at academic skills and competences, Ewing- Cobbs et al (2004) found that children and adolescents with severe ABI received lower scores on tests of arithmetic, spelling, word decoding, and reading comprehension. Ewing- Cobbs et al (2004) found a 'striking' difference between academic achievement scores and parent ratings of academic performance. That is, even given adequate development of basic academic skills, actual classroom performance was low, suggesting that other factors were impacting on an individual's performance. Such factors may include other cognitive deficits such as memory and concentration, motivation, social rejection, self esteem and poor self identity. Children with severe ABI have scored lower than either

children with mild injuries or community controls on a variety of achievement scores during the early stages of recovery as well as six months to several years after the injury (Barnes et al, 1999; Ewing- Cobbs et al, 1998). This information supports that idea that the cognitive difficulties experienced after a head injury will be dependant on the severity of the injury and therefore the type of intervention and level of recovery that we might expect, depending on the extent of injury.

Damage to the frontal lobe area may also impact the development of social awareness and emotional literacy. Research has identified persistent difficulties in the following areas; irritability, inattentiveness (Asarnow et al, 1991; Knights et al, 1991) and poor social competence (Butler et al, 1997). In addition, children are also dealing with the trauma of a head injury which may include physical difficulties and loss of their former identity. Children with severe ABI are significantly more likely to receive special educational services 1 to 2 years after their injury (Donders, 1994) which may mean that they have to adjust to a different school with unfamiliar teachers and peers. Those returning to mainstream after a long break in rehabilitation services may also feel isolated from friendship groups and activities that they may feel less competent in joining in. There may then be a significant impact upon the child's emotional wellbeing and their capacity to identify and deal with their emotions.

The impact of an ABI is widespread; there is often a major and ongoing impact on families (Middleton, 2001), who may be feeling stressed, pressured and emotional. There may also be financial implications if one or both parents have had to have significant periods of time off work to support the child and manage hospital visits, appointments etc. Problems within the family often go unrecognised and can become entrenched and difficult to shift if they are not addressed (Doherty & McCusker, 2005) through the support of professionals.

Emotional difficulties experienced by children with an ABI may therefore be directly related to the parts of the brain that have been injured; they may be trauma related, they may result from the realisation of cognitive and social difficulties or constitute a reaction to peer and family difficulties (Doherty & McCusker, 2005). The likelihood is that a combination of all of these factors will contribute to impaired social and emotional functioning.

5.5 The process of reintegration

Education is seen as an important aspect of an individual's recovery from an ABI. Education both in and out of hospital allows a child to recover and develop their memory strategies, organisation and planning skills (British Psychological Society, 2004), all of which are essential in allowing the child to access the national curriculum when they return to school. Whilst this may take less of a priory during the acute stage of recovery, the education of children with an ABI takes a more prominent role during the later stage of recovery and may take place whilst the child is still in hospital. Some hospitals may have specialised teachers who work with the rehabilitation team to offer an individual curriculum to the child for a few hours per day, other hospitals have schools attached to them where such teaching is delivered (British Psychological Society, 2004).

It is the responsibility of the community health services to notify the local authority of any child whom they believe may have special educational needs (SEN) following from an ABI (British Psychological Society, 2004). If the child has sufficient residual difficulties and health problems that have a significant impact on his or her education then a Statutory Assessment of Special Educational Needs may be requested. This process is useful in that it pulls a range of knowledge and expertise together to assess the needs of the child. In the case of children with an ABI, it is essential to include the neuropsychological needs of the child and specify particular strategies and interventions that teachers can put into action (British Psychological Society, 2004). Of course, many children with an ABI may demonstrate an effective recovery after the incident and therefore return to their mainstream school. However subtle cognitive deficits may become apparent over time when higher order learning skills are required and with changing demands brought to the child in later life. Thus, there is a need for prolonged multi agency working around a child with ABI to coordinate further assessments, provision and progress.

Statutory assessment makes this process more formal in that Annual Reviews are coordinated to assess the progress of the child, although not all children with an ABI will meet criteria for statutory assessment and it is therefore essential for professionals working closely with these children to be aware of both their history and the impact of

ABI. Doherty & McCusker (2005) examined the functional and psychosocial outcomes for children and families four years after children had experienced a severe head injury and found that both the amount and type of professional involvement decreased over time despite the fact that half of the children in their sample continued to have significant difficulties. Psychologists were also seen fewer than 15 times by the 19 children injured since their discharge from hospital and yet the difficulties experienced by the children were behavioural and cognitive in nature. Doherty & McCusker (2005) concluded that there appears to be a discrepancy between the needs and provision available for children with severe brain injuries, with those that attend special schools receiving more professional involvement.

5.6 Education as rehabilitation

As detailed above, cognitive deficits are frequent consequences of ABI. Such deficits will have a direct impact on an individual's academic ability and achievements. There are a number of cognitive rehabilitation interventions, all of which aim to maximise a child's educational and life outcomes. Slomine and Locascio (2009) reviewed the theoretical and empirical literature on cognitive rehabilitation in a variety of treatment domains including attention, memory, speech and language, executive functioning, and family involvement/education. The last of these is particularly relevant to the current study. Slomine and Locascio (2009) note that for many children with ABI, cognitive interventions are routinely implemented by teachers as part of the child's educational programme. In addition, parents and other caregivers play an essential role in structuring the child's environment in a manner to promote optimal functioning. Interventions carried out by people in the child's immediate environment such as home and school need to be considered within the broad definition of cognitive rehabilitation. The review by Slomine and Locascio (2009) states that families and educators have a powerful role to play within any given rehabilitation programme and where possible children with an ABI should be rehabilitated within their naturalistic and educational settings. This is also supported by findings from Ylvisaker (1998) and Braga et al (2005). The review concludes by stating that professionals working with children with an ABI should ensure that the provision and services offered to children and their families are appropriate and within this, caregivers and educators should be trained to implement interventions within the

child's everyday life. Education then is seen as a vital part of a child's recovery and professionals around the child should have a sound knowledge base of the types of intervention programs that could be offered in schools as part of a child's recovery programme. Professionals also need to draw from other evidence such as literature on children with neurodevelopmental disabilities and typically developing children in considering appropriate cognitive rehabilitation strategies (Slomine & Locascio, 2009).

5.7 The role of the EP

EPs have a key role to play in the statutory assessment process and are also in a unique position to help school staff to address the needs of children with an ABI. The British Psychological Society (2004) recommends that the EP needs to get involved before a child returns to school in order to ensure that the provision is suitable to their current needs, and that reasonable adjustments have been made where necessary. EPs can also:

- assist staff in developing effective strategies and approaches for teaching;
- participate in assessment and monitoring of progress;
- counsel parents who need to be reassured that their child's educational needs are well met;
- coordinate in service activities to promote greater understanding of ABI and its educational implications;
- carry out research into the integration of children with ABI into their schools;
- advise LAs about the needs of pupils with ABI and appropriate provision; and
- encourage preventative work.

(Taken from the British Psychological Society, 2004, p.35).

5.8 Concluding synthesis

The literature review highlights several pertinent points which each has a range of implications for professionals who are supporting children with an ABI. Firstly, the age when the child experienced the injury is a key piece of information. The research

suggests that children who experience an ABI before the age of seven or eight are likely to demonstrate poorer outcomes than those who experience an ABI at a later age. This is because the immature brain is yet to develop key functions, and damage at this age may prevent or impair the later development of such functions. The research discussed above also highlights the far ranging effects of an ABI. Children who have had an ABI may experience a range of cognitive difficulties but also may experience difficulties with emotional regulation, social skills and behaviour. It may be difficult for a child to accept or begin to understand their new identity, which may have a subsequent effect of their emotional wellbeing and self esteem.

Psychology then has a key role to play in supporting the range of needs of children with ABI and their families.

The research also highlights the importance of education during a child's rehabilitation. Studies have also shown that where families were supported to carry out structured interventions and support for the child at home in their naturalist setting, children demonstrated significant marked improvements compared to other children who had received more traditional therapy within a clinical setting. There is then a key role here in supporting parents and educators to carry out specific interventions within the child's natural environment i.e. home and school, a role that would draw on the unique and far ranging skill base of the EP.

5.9 Background to current research

The current literature review suggests that education is an essential part of the rehabilitation process for children with an acquired brain injury; damage to the brain predominantly causes cognitive difficulties for which the most appropriate rehabilitation is within educational settings (Walker & Wicks, 2005). The review would also suggest that EPs are well placed within the context of schools to support individual children who have experienced an ABI, their family and teaching staff. The work of EPs in this context could include individual assessment and observations, consultation with teaching staff, training and enhancing knowledge of the individuals specific needs and injury, working with parents, working with other professionals or signposting to other appropriate agencies and support staff for example community

charity services such as those offered in some areas by the Child Brain Injury Trust (CBIT).

EPs with a sound knowledge base of ABI could be a fundamental resource in facilitating and supporting the rehabilitation of children with ABI back into fulltime education. The researcher was therfore keen to explore whether EPs wide based skills were being utilised in this context and also where and how EPs could best support the subgroup of children who may have life long educational, social and emotional needs.

The aim of the current research was to explore the recovery and reintegration process of children with an ABI and to consider the role of EPs within the local authority in supporting these processes. There are many different referral pathways that children may experience after an ABI, and these pathways will depend on the nature and severity of their injuries. This study has focused on exploring two specific contexts that support the needs of children with severe brain injuries. The first is a specialist rehabilitation centre and the second is a local children's hospital that is nationally recognised for their specialism in paediatric neurology.

5.9.1 Aims of the research

1. To explore the perceived role of the EP in supporting rehabilitation for children with an ABI;
2. To explore ways in which local authority EPs could further support children with ABI and their families in one local authority.

5.9.2 Research questions

1. In the judgement of professionals working in two specialised settings, do EPs have a role to play in supporting the rehabilitation of children with an ABI back into education?
2. Is this role currently being utilised?
3. What are the facilitating factors and barriers to using EPs to support children with ABI and their families throughout their rehabilitation?

5.9.3 Method

Semi-structured interviews were used as the primary method of data collection for the current piece of research. Robson (2002) describes semi-structured interviews as an interview that has predetermined questions, although the order can be modified based upon the interviewer's perception of what seems most appropriate. Question wording can be changed and explanations given, particular questions which seem inappropriate with a particular interviewee can be omitted, or additional ones included. Interview schedules were therefore prepared before each interview; questions varied depending on the role of the participants.

The interview schedules consisted of a number of questions that fell into three main categories which were processes, roles, role of the EP and rehabilitation. In order to build a richer picture of each of the settings, the researcher was keen to find out more about the processes or referral and the roles that each participant undertook within the process of acute care, recovery and rehabilitation. Part of the interview was therefore about exploring each of the contexts as well as asking specific questions about the role of the EP in supporting rehabilitation into full time education and the wider community. Information from the literature review, discussion with colleagues and academic supervision led to the development of the questions used in the interview schedules (See Appendix 1 for copies of each interview schedule).

The interview is a flexible and adaptable way of finding things out. Face to face interviews offer the possibility of modifying one's lines of enquiry. Responses can be followed up in more detail, and non verbal cues can be detected which may provide a more accurate perception of the individual's constructs and feelings towards a particular subject. Such responses may not be detected in self administered questionnaires or interviews conducted over the telephone (Robson, 2002).

One of the main drawbacks of using an interview in this particular case is the issue of subjectivity. From a constructivist perspective, each individual has their own constructions of their social environment and when interpreting data from each interview, it may be possible for the interviewer (who is also the researcher) to interpret the data using their own constructions which are likely to be quite different

from each of the interviewees. It is therefore important to bear this in mind when analysing the data. One possible way to reduce subjectivity when analysing the data is to record the interview using a dictaphone and then to transcribe the data (with consent). The interview is therefore recorded and may reduce the likelihood of the interviewer making notes of the points they feel are most useful which would inevitably be impacted by their own preconceptions and constructions of the world. However, such subjectivity and bias may also be apparent during the coding of the data. In this study, all of the interviews were recorded and transcribed by the researcher.

5.9.4 Participants

The following professionals were interviewed from a specialised rehabilitation centre for children with an ABI: a speech and language therapist, two educational psychologists, a clinical psychologist, an occupational therapist and the headteacher of a medical pupil referral unit attached to the centre.

In addition, a paediatric neuropsychologist and a clinical psychologist were interviewed from a nationally recognised children's hospital that specialises in neurology and brain injury.

5.9.5 Procedure

Informed consent was gained from each participant (See Appendix 2 for a copy of the consent forms). The consent forms included information about the use of a dictaphone and participants were given the choice at the beginning of the interview to refuse the use of a dictaphone.

In accordance with ethical guidelines published by the British Psychological Society (2009), participants were also told that they had the right to withdraw from the research without giving a reason and that any information collected from them to date could also be withdrawn. Participants were also informed that their views would be anonymous; that is their names would not be mentioned as part of this research although their job titles may be referred to.

All of the interviews were conducted in a private quiet room and lasted between 20-50 minutes (See Appendix 1 for individual interview questions). Participants were thanked for their time and given the option to request a copy of the final report if they were interested in further reading. A copy of each transcript was sent to each of the participants to ensure that the views reported in the research were indeed an accurate reflection of the views they hold. Participants were given an opportunity to amend or add any further information before their interview transcripts were analysed. One participant added more details to her interview transcript.

5.9.7 Analysis

The aim of the interviews was to explore participants' perceptions of what the role of the EP should be in supporting rehabilitation for children with an ABI and how the skills of the EP could be utilised to fulfil this role. Each of the interviews were recorded and transcribed. Additional notes were also made during each interview. The transcriptions were analysed using thematic analysis which is a method for identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). Thematic analysis is an accessible and theoretically flexible way of exploring themes across a whole data set whilst also allowing individual views to be represented and so it was felt that this was the most appropriate tool of analysing the themes from the interviews.

Braun and Clarke (2006) provide an accessible step by step guide to conducting a thematic analysis which was broadly followed for the purpose of analysing the data in the current study (see Appendix 3 for a more detailed account of the process used to identify themes from the interview transcripts). The researcher carried out all of the interviews and transcribed all of the data in order to become familiar with the data. Braun and Clarke (2006) suggest that 'it is vital that you immerse yourself in the data to the extent that you are familiar with the depth and breadth of the content' (pp.87). Immersion usually involves repeated reading (Braun & Clarke, 2006) and so each transcript was read several times over before themes were formally generated. Whilst final themes were not generated at this time, the transcripts were marked with some codes and themes which were revisited at a later stage. The exploration of meaning, patterns and themes therefore began at the point of transcribing the data which

continued to be developed and defined throughout the entire analysis. Key sentences, phrases or paragraphs were then coded and from these codes key themes and subthemes were generated, reviewed and refined. A number of developmental thematic maps were produced throughout this process and refined to produce a final thematic map as demonstrated in the results section.

5.10 Results and discussion

The first set of interview questions for each of the participants aimed to explore the referral process and roles within both the specialist rehabilitation centre and the nationally recognised children's hospital. This data was not analysed using thematic analysis but rather was used to gain a general overview of the two settings as they were both unfamiliar to the researcher. In addition, information booklets from the settings were used to gain more information on the background and role of each setting. The information below therefore provides an overview of each of the settings to allow the reader to gain an insight into how the two settings differ.

5.10.1 Specialist rehabilitation centre

This is a multi disciplinary centre that provides initial assessment and support for children and young people usually just coming out of hospital after experiencing an ABI. The rehabilitation and therapy services provide intensive residential rehabilitation programmes and support at home for children and families. The cause of ABIs for children and young people receiving residential rehabilitation at the centre is extremely varied (see figure 1).

Children and young people are usually referred to the centre from a member of staff at a local hospital. An initial assessment of the individual's needs will be undertaken to determine whether such needs can be met by the centre. Children and young people will then initially undertake a short-term stay at the centre (usually between 6 weeks to 3 months) where initial assessments and therapeutic work are coordinated from a range of professionals within the team. Some children may then stay for an extended period before returning to either their previous school or an alternative provision

within their local authority. The length of the rehabilitation period at the centre will depend on funding from the patient's local Primary Care Trust.

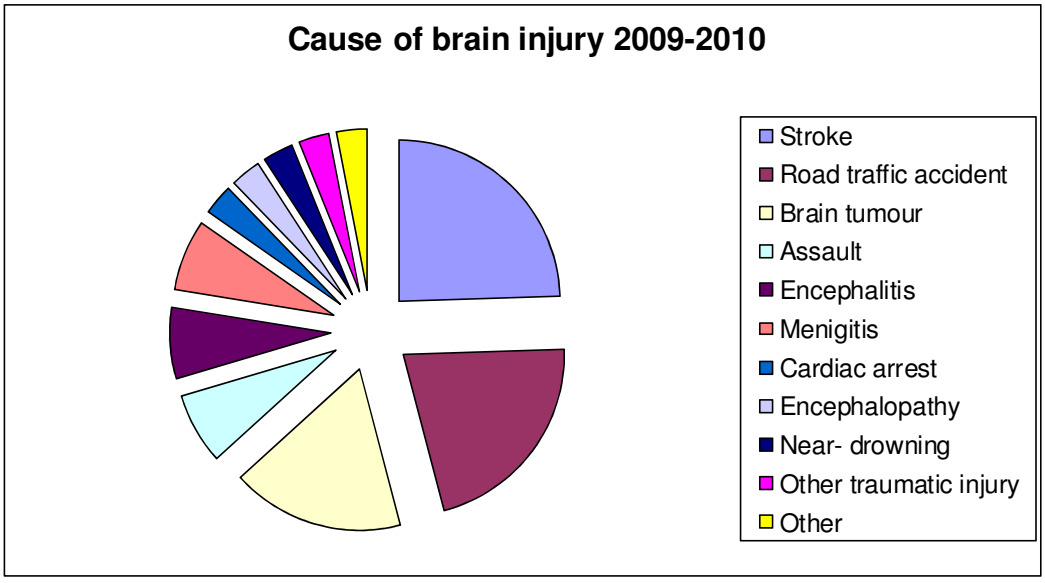


Figure 1. A visual representation of the causes of ABI for children and young people receiving residential rehabilitation at a specialist centre. This data derived from an information booklet that was produced by the setting. The information did not include further details on the age or age ranges of individuals.

5.10.2 The children's hospital

The local children's hospital has a neurological rehabilitation team that is led by a community paediatrician. The team consists of a clinical psychologist, an occupational therapist, a physiotherapist and a teacher. The team work with children who have had a road traffic accident or an ABI which includes children who may have experienced a hypoxic injury during surgery or cardiopulmonary resuscitation. The team therefore work with children during the acute stages of their recovery. When the patient is classified as medically stable, s/he will move on to either a specialist rehabilitation centre such as the other setting in this study (funding-dependent) or will return home. There are a number of care staff who work on the ward with children who have experienced an ABI, although these members of staff work on a rotation basis. Some children who have experienced more mild head injuries are likely to see the paediatrician although the team may not necessarily have

contact with the patient. Of the last 12 patients with whom the team have been involved, seven sustained an ABI from a road traffic accident, three from spontaneous bleeds on the brain and two had infections or an abscess on the brain (see figure 2 for a visual representation). Interviewees from this setting were unable to provide information about the age or age range of individuals they were referring to.

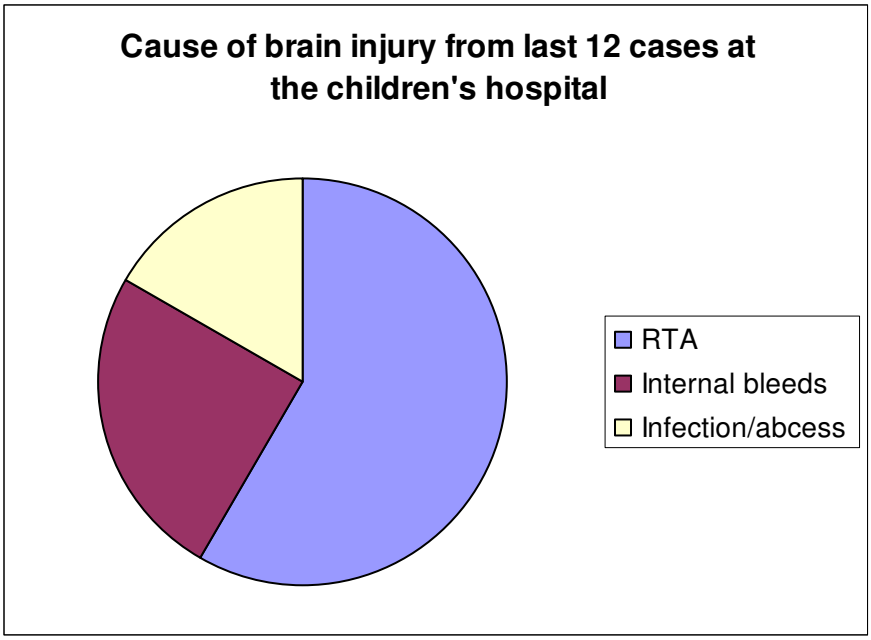
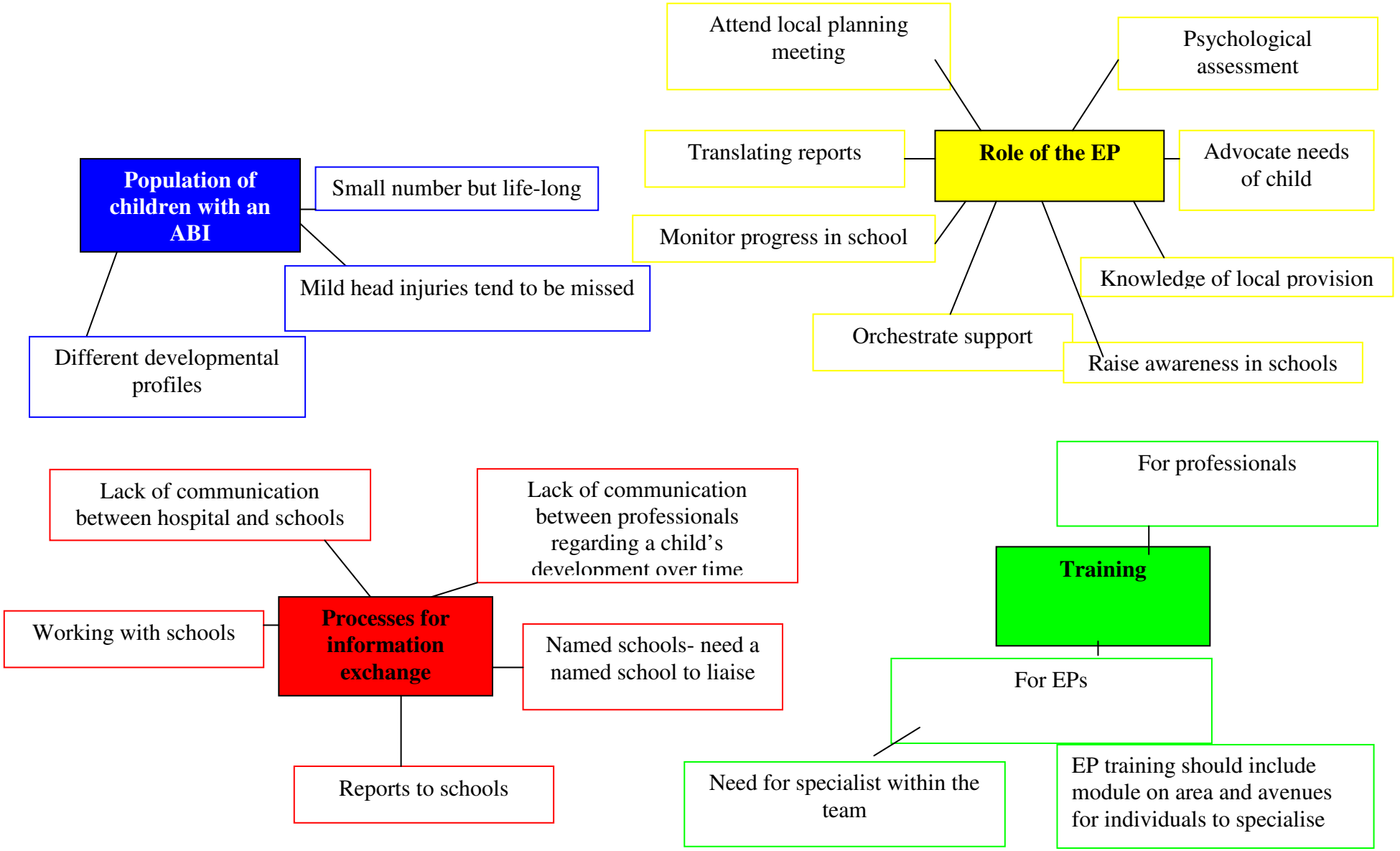


Figure 2. Cause of brain injury from the last 12 cases at the children's hospital.

5.11 Thematic analysis

Whilst the data that described the referral process and roles within each of the settings were not analysed using thematic analysis, the rest of the data was and this was used to produce a range of thematic maps as part of the analysing process. Figure 3 demonstrates a final thematic map which details the overall themes and sub-themes abstracted from the data.


Population of children with an ABI
Small number but life-long
Mild head injuries tend to be missed
Different developmental profiles
Role of the EP
Attend local planning meeting
Psychological assessment
Translating reports
Advocate needs of child
Monitor progress in school
Knowledge of local provision
Orchestrate support
Raise awareness in schools
Processes for information exchange
Lack of communication between hospital and schools
Lack of communication between professionals regarding a child's development over time
Working with schools
Named schools- need a named school to liaise
Reports to schools
Training
For professionals
For EPs
Need for specialist within the team
EP training should include module on area and avenues for individuals to specialise

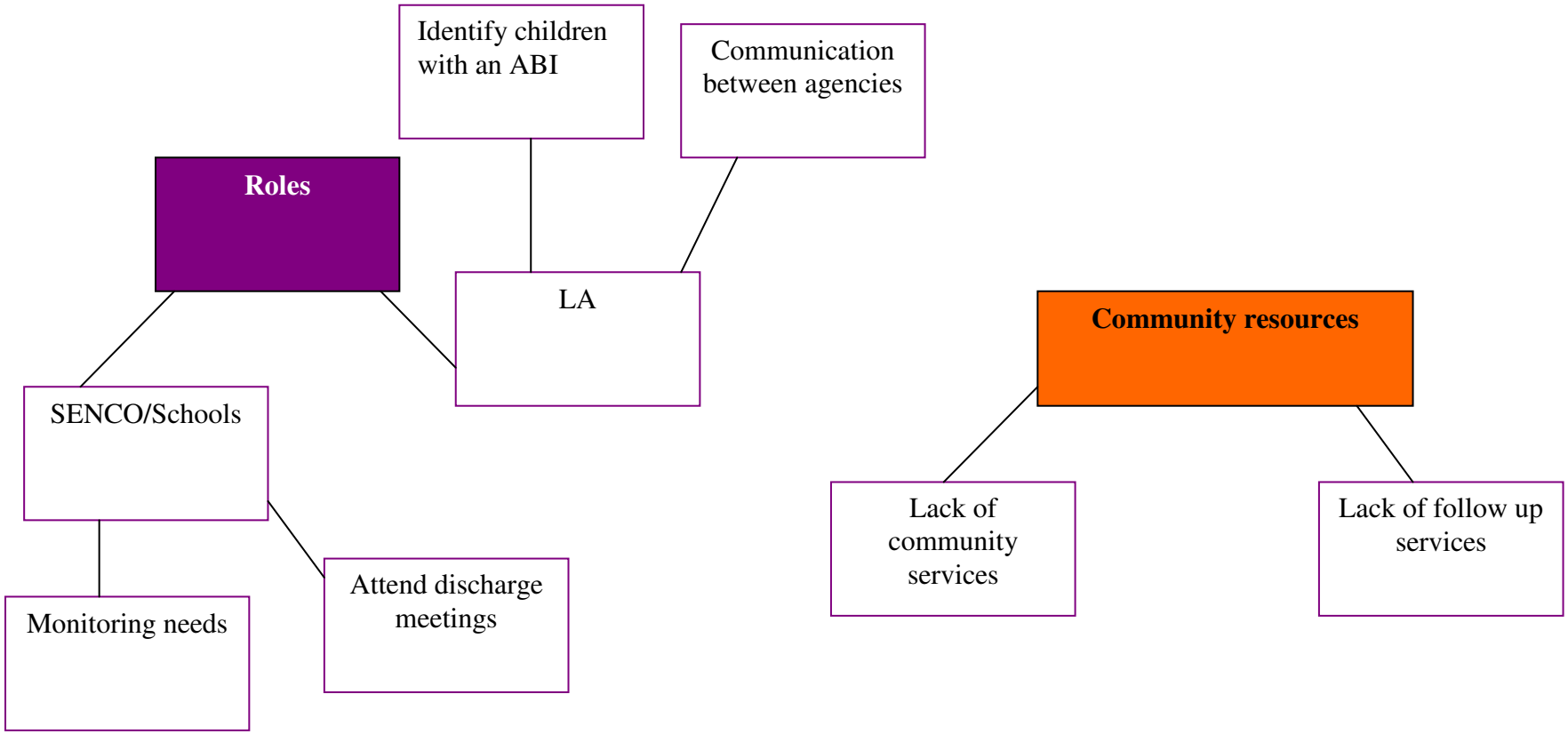


Figure 3. A visual representation of the final thematic map

The themes that were generated from the data were derived from key quotes from participants. The section below provides some examples of key quotes within each theme and reflects upon how these themes exist alongside findings from the literature review.

5.12 Population of children with an ABI

The population of children with severe ABI is relatively small, although the impact of a severe injury is far reaching and life long and thus intervention over time is essential:

> **'**If we can get in now and have a structured approach we can create massive changes for them but as X said they are actually quite a small group but if you don't do anything the impact is massive.' (Interview at the children's hospital)

Whilst children with more severe ABIs are likely to receive input from a rehabilitation team, the needs of children with moderate to mild injuries might be missed. There is no mechanism in place to inform schools that an injury has occurred if the injury is mild and the child has not stayed in hospital for more than a few days and yet as the young brain develops there are likely to be implications of the injury that schools should be educated about:

> 'We also get some that come in for 24/48 hours. The head consultant will try to find out about them and follow them up but the rest of us won't always get involved. So there is potentially a large group of children with mild head injuries that we don't really get to see and we don't really know what happens' (Interview at the children's hospital).

> 'The statistics are that you have a 1/15 chance of having a head injury by the time you are 15 that requires some treatment and head injuries account for around 1/3 of all admissions in terms of accidents and account for a substantial number of deaths in children as well' (Interview at the children's hospital).

Whilst the population of children with severe ABI is relatively small, a large number of children experience mild/moderate head injuries which may or may not lead to significant difficulties but there are no protocols or processes in place to record these injuries by their severity, to aid communication between professionals and to monitor the progress of these children:

> 'My dream I suppose would be that the EP has contacts with the LA who has a key person responsible for keeping a register of children in the area who have had an ABI and alert the school that this child is going to be returning' (Interview at the children's hospital).

> 'I think it would be a good idea for schools, EPs and local authorities to have a list of those children that have had an ABI. Even having that as a protocol would be helpful and being able to keep an eye on them on an annual basis because they are going to be the children who may end up in trouble and perhaps be excluded, not because it's their fault but because they might have difficulties coping especially with tasks such as homework and as a result may become disaffected' (Head of PRU, specialist rehabilitation centre).

The latter two quotes highlight two other pertinent points, communication between agencies and processes for information exchange.

5.13 Processes for information exchange

Several key processes to support the exchange of information about a child with an ABI were identified. These included the use of discharge meetings:

> 'We have a discharge planning meeting quite early on really to which we try to get someone from school to come along to as well as maybe the community nurse or social services, often it's the SENCO that comes along to those meetings they get involved quite earlier on' (Interview at the children's hospital).

> ‘Discharge involves handing over to a range of professionals or our counterparts in the local community who we hope will continue to support. What we have to impress on the EP is the enduring and chronic nature of ABI, so the child is not likely to get back to the way they were before the injury and it’s the EP who is really well placed to follow the child up from class to class, school to school and for that EP to bring in other people who may be able to support if need be, but yes the LA EP has a crucial role’ (EPs from the specialist rehabilitation centre).

It seems that one of the key roles for EPs then is to attend those initial discharge meetings which may be held at the hospital, the school or the rehabilitation centre. Often it is the EPS that remains constantly involved with the child through their school life and therefore could be a key agency to communicate information about the injury much further the line.

Other processes that were deemed to be important were the communications that happened between hospital schools and mainstream schools. It was also thought that the use of discharge reports with key recommendations were a useful way of communicating the needs of a child with an ABI although another key role of the EP might be to translate the meaning of medical/neurological jargon into practical information that can be applied in the school setting:

> ‘Another thing that we haven’t referred to in terms of the role of the LA EP is the ability to translate a clinical report into what might be useful for the school’ (EPs from rehabilitation centre).

This relates to the work of Bozic & Morris (2005) who found that current training programmes and continued professional development opportunities for EPs do not routinely address issues concerned with ABI. Perhaps if EPs did have this initial knowledge base then they would be better able to translate medical and

neuropsychological reports into actions that could be implemented within the context of education.

5.14 Training for professionals

Doherty & McClusker (2005) argue that children who sustain a head injury (not necessarily one described as severe) should be identified and follow a care pathway which follows them from hospital discharge through at least their first two years and ideally longer. General practitioners and schools should be alerted of the occurrence of the head injury and be educated regarding the implications that this may have for the child. Schools do tend to be informed of a head injury when the injury is classed as severe. Both the local children's hospital and the rehabilitation centre offer discharge meetings or local planning meetings where there is an opportunity to discuss the nature of the injury, its implications and future educational provision. The specialist rehabilitation centre also offer training to schools which details how the brain works generally and then more specifically the exact injury that a child has sustained and the implications that this is likely to have on their academic, social and emotional functioning. This was seen as a useful way to communicate with schools, however this is only available from the specialist rehabilitation centre for those children that have had a moderate/severe injury and have secured funding to go to the centre. Moreover, the centre can provide the initial training but do not currently provide long term follow up support for the child or the school. Some children will return home directly from hospital and later return to school. In these cases then, it is unlikely that schools will be educated about the needs of a child with an ABI. Moreover, children who experience moderate to mild head injuries are unlikely to go to specialist rehabilitation services and may be out of hospital within days of their injury and thus this much larger group are even less likely to receive professional support outside of their initial medical care.

The literature review drew on the work of Slomine & Locascio (2009). In their review of cognitive rehabilitation programmes, they concluded by suggesting that interventions should be carried out in the child naturalistic and educational settings

and that educators and professionals around them should be trained in how to carry out specific interventions. They also referred to a study by Braga et al (2005) who found that training families to carry out specific interventions led to significantly improved outcomes for children with ABI compared to those who reviewed traditional rehabilitation delivered by clinicians in a clinic. Both the literature review and the findings from this study would suggest that there is an absolute need to train those individuals working around the child in both home and school settings about rehabilitation and brain injury so that they can utilise the time spent in the classroom to maximise the potential for the successful rehabilitation of cognitive skills.

The cognitive, emotional, social and behavioural deficits that follow an ABI are likely to become more apparent over time when new functions of the brain develop, thus the needs of a child who has sustained an ABI years previously are likely to change over time. In addition, staff who may have been originally educated about an individual's ABI may have moved on or the child may have moved to a different school. Perhaps then, there is a need for the continued monitoring of children who have had an ABI with opportunities to educate and support staff who are working with such individuals throughout their school life:

> 'Well the EP could have the role of each year or each transition to remind the schools that that person still has ongoing needs and to keep that flexibility that they may be ok for this year but that doesn't mean that they will be for the following year and the EP is the person who may be the continuity throughout that' (Occupational Therapist, specialist rehabilitation centre')

> 'I think a lot of it is about educating the teaching network about the needs of that child to help staff to understand the academic presentation of that child and how they will present in terms of social difficulties. I think there is a real education role as well as communicating the changes that that child has experienced and sometimes teachers may not appreciate the sheer change between life before and life now for the child' (Clinical Psychologist, specialist rehabilitation centre referring to the role of the EP in the LA).

5.15 Training for EPs

EPs could have a key role to play in monitoring the progress of children with an ABI and also in educating staff and families about the changing needs of the child and the implications of their head injury. However this may require more specialist training for EPs:

> 'I think there is a real need for training for EPs to understand ABI and the nature of the educational implications which is something that EPs don't have an in-depth of knowledge of but would definitely benefit from. And we are talking about the moderate to severe end but there are a number of other children going from other places with milder injuries. I am sure there is an interest and a willingness that just needs to be rolled into a CPD or training programme. It is such a rich area to tap and so important. If there was an EP in each area that had this specialism that could work very well' (EP, specialist rehabilitation centre).

> 'It seems to me that it would make more sense to have someone dedicated that was maybe a child neuropsychologist or at least had some expertise and awareness of where to refer children onto but would cover schools with certain parts of the behaviour support for these children. People may have an aspect of their job that could be dedicated to that population. It would make sense to have one or two specialist EPs that could go into schools' (Interview at the children's hospital).

> 'Actually the EP is in situ and a great position to be able to train teachers about behaviour management strategies, cognitive strategies etc. The genuine feeling was that EPs didn't feel that they have the training to do this and I think that would be true nationally. Our experience in this area is that EPs have very little input in this area' (Interview at the children's hospital).

Bozic and Morris (2005) conducted a small scale questionnaire based survey among a sample of EPs. One of the aims of this study was to explore the extent to which EPs

considered their initial professional training had equipped them with the knowledge and skills that might underpin work with children who had an ABI. A minority of EPs indicated that their initial training or subsequent continued professional development activities had addressed issues concerned with ABI in any level of depth and 'has afforded either very little or no preparation for this area of practice in approximately 80% of cases' (Bozic & Morris, 2005, pp.117). Perhaps then EPs may not feel equipped with the skills or confidence to support the reintegration of children with an ABI back into education and yet the current study would suggest that EPs could have a vital role to play in this process. Bozic and Morris (2005) concluded that work with children and young people with ABI is 'indeed, in some regards, currently an underdeveloped dimension of educational psychology service delivery' (pp.117) and 'there is a need to further develop the capacity of individual EPs and services to develop an enhanced range and quality of provision' (pp.118) for children with an ABI.

5.16 Roles of the LA, school and the EP

Some of the key roles of the EP in supporting children and families of children who have an ABI have been mentioned previously, i.e. attending discharge meetings, translating reports, training school staff about the needs of children with an ABI, raising awareness of this group of children and monitoring the progress of children with an ABI. This latter point may simply be a case of ensuring that these children are raised at planning meetings and that the profile of these children is seen as a high priority across schools.

In addition, the EP was seen as a key person who facilitated meetings and orchestrated support within the community:

> 'They have just seemed to pull together all the professionals so the schools that have attended are more knowledgeable about what the child's needs are going to be' (Speech and Language Therapist, specialised rehabilitation centre).

EPs also have knowledge of the local provision and can therefore coordinate services with alterative provisions to ensure that the needs of children with an ABI are fully explained and met appropriately within a local school, whether it is a special school or a mainstream school:

'We know about the child needs but the EP knows more about the local area and what the provision is and what is realistic' (Speech and Language Therapist, specialised rehabilitation centre).

Whilst special schools have a range of expertise and experience when working with children who have special educational needs, children with an ABI may present quite differently to those that have a developmental disorder for example. There are wider issues to consider such as the loss of identity, the loss of physical and cognitive skills, dealing with trauma and bereavement and complex family issues. EPs may also have a useful role to play in supporting special schools at a consultation level to develop appropriate strategies and individual education and behavioural plans (DfEE, 1994):

'From my experience, the EP has a very little role in supporting this process in special schools i.e., designing targets and supporting teachers through this process' (Interview at the Children's Hospital).

For EPs to have a knowledge of an individual's needs it is important for them to liaise with the rehabilitation team regardless of whether this is part of the statutory assessment process or not:

'EPs will occasionally visit for a specific child and I might be able to sit with them and talk through the issues that present for that child, either the neuropsychological, emotional or social issues. I can talk with them about what their needs might be within an educational setting so there could be some face

to face work with that or that could be done by phone' (Clinical psychology, specialist rehabilitation team).

EPs then appear to have a key role in supporting children with an ABI at a number of levels; at the individual level EPs can identify specific areas of need and monitor the progress of children. At a school level EPs can work with staff to help them understand the changing and developmental needs of the whole child and how these needs could be met in school. At a wider systems level, EPs also have a key role to play in supporting families and facilitating support for children when they finish their formal rehabilitation and are integrated back into school.

Several interviewees mentioned the importance of having a system that recorded all children that had been admitted to hospital because of a head injury and the severity of the injury should also be detailed. Local authorities therefore could develop a protocol that allowed EPs and other professionals in schools to be notified when a child has been admitted to hospital due to a head injury where the injury may lead to future difficulties.

If schools and particularly SENCOs were aware of this then they could monitor the progress of these children and involve the EP at a much earlier stage which may prevent professionals misunderstanding the origins of cognitive, social, emotional or behavioural difficulties further down the line. As a result, interventions would be targeted using information and strategies from brain injury research.

Whilst several key processes for information exchange were identified throughout the interviews, the majority of interviewees raised the lack of communication between professionals as being a key barrier to supporting children with an ABI. This was particularly likely to occur where a child had received an ABI a long time previously and new professionals now working with the child had not been made aware of the injury and its implications. In addition, professionals at the rehabilitation centre found

it difficult to communicate information about the needs of a child where the school that the child was returning to had not been named by the time they left the centre.

5.17 Community resources

Many of the interviewees raised the issue of resources within the community and follow up support as they felt that there was a lack of services and professionals within the community that could support these children. From the children's hospital, once children were seen as medically stable they were allowed to go home but there are limited resources in the community to continue their rehabilitation unless they go onto a specialised rehabilitation centre. Where children go on to a mainstream school or special school, some support may be available although it is unlikely that professionals in these settings will have an in-depth knowledge and awareness of the implications of an ABI without further training which is only provided from the specialist rehabilitation centre if a child has attended this provision:

> 'There aren't services to look after children with ABI and the level of experience for people to do that' (Interview with the children's hospital).

> 'We know that there is still an ongoing need for rehabilitation but we can't always find that in the community' (Interview with the children's hospital).

> 'It's not always appropriate for children to stay in acute care for that amount of time because that does create issues for the relationships that they form with staff and how appropriate that is and they are not at a level where they will need that type of care but they will need intensive rehab that will help them to continue to progress and we do not have that. So they are left in limbo' (Interview with the children's hospital).

'We are not currently following up children long term… it's the EP who is really well placed to follow the child up from class to class, school to school and for that EP to bring in other people who may be able to support if need be, but yes the LA EP has a crucial role' (EPs, specialist rehabilitation centre).

'It can be difficult because here we have such an intensive setup, you identify everything and then the child goes into the community and there is not the follow up from the therapy but that's when it is good to have the EP involved who can be a central person to carry it through with the school' (Speech and Language Therapist, specialist rehabilitation centre).

5.18 Research questions

The initial research questions presented at the beginning of the research that were derived from both findings from the literature review and discussion with colleagues who also have an interest in the area of ABI and neuropsychology were as follows:

1. In the judgement of professionals working in two specialised settings, do EPs have a role to play in supporting the rehabilitation of children with an ABI back into education and if so, is this role currently being utilised?
2. Is this role currently being utilised?
3. What are the facilitating factors and barriers to using EPs to support children with ABI and their families throughout their rehabilitation?

With regards to Research Question One, the data would suggest that EPs definitely do have a role to play in supporting the rehabilitation of children with an ABI back into education. The literature review demonstrated that education is a vital part of the rehabilitation process when a child has experienced an ABI and therfore EPs should have an up to knowledge and awareness of the unique issues associated with brain injury. Participants described a range of functions that the EP could deliver which included attending planning meetings when child was initially released from a specialised rehabilitation centre or hospital, monitoring those

children who had experienced an ABI, facilitating multi agency meetings, training a range of professions about the needs of children with ABI and enhancing awareness about how to support such children and their families.

With regards to research question two, the data from participants would suggest that whilst EPs do tend to be involved with those children who are going through the statutory assessment process they are not always used at the beginning of the process, skills in areas such as research and training professionals about the needs of children with ABI do not seem to be core areas of work for EPs that participants in the two settings have worked with. One of the possible barriers to EPs being involved in this type of work is a perceived lack of in-depth knowledge and further training in the area and this was certainly a prominent point that was highlighted during the interviews with participants. There does seem to be a gap or need amongst EPs for the development of specialised knowledge in this area.

A further barrier to working with children with ABI is identifying where these children are in the first instance and this is particularly apparent for those children who have experienced a mild head injury. EPs are ideally located to work with schools, children and their families to support the reintegration of children who have experienced an ABI. In addition, EPs are highly skilled to work with families and schools to deliver a range of support including designing specific interventions, transition plans and delivering training to professionals. EPs also have a prominent role to play in the assessment of needs and are in a position where they can continue to monitor an individual's educational, social and emotional needs. There are a number of ways forward or recommendations for services with a view to enhance outcomes and support for children with an ABI.

5.19 Conclusion

This small scale research study has highlighted a number of areas to which EPs can contribute in supporting children who have had an ABI. Whilst the numbers of children who have had a severe ABI are low (although the identification of children

with mild head injuries is poor and so the number of children who have been affected by ABI may be much higher than currently predicted), their needs are far ranging and can be life long. It appears that there is a need to develop the knowledge and skills of EPs through enhanced training and within this develop the capacity of EPSs to respond to a range of needs from schools and families. In particular, the development of specific training packages aiming to develop the knowledge and skills of key practitioners working with children and young people who have an ABI could be offered to schools, families and other settings.

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5.20 APPENDICES

Appendix 1- Interview schedules for all the semi structured interviews that were completed

Appendix 2- An example of the consent forms used for all participants

Appendix 3- The process of thematic analysis (Braun and Clarke, 2006)

Appendix 4- An example of an interview transcript from the children's hospital interview

Appendix 5- A snapshot of how some of the key themes generated from the data

Appendix 6- A glossary of medical terms used.

Appendix 1- Interview schedules for all the semi structured interviews

Interview schedule 1:

Heather Ball
02/12/2010
Interview schedule
Birmingham Children's Hospital

Participant's role: Paediatric Neuropsychologist and Clinical Psychologist

1. Introductions
2. Purpose of the interview
3. Consent and ethical considerations

4. Interview structure

Processes

How are children referred to you?
What is the referral process? And who decides which children you see?
What is the nature of injury of the children you see?
Do children tend to have an acquired brain injury caused by an external impact?
What are the main needs of children referred to your team?
Are there hospital based schools at Birmingham?
Which children attend these schools? And for how long?
Do the children that you work with tend to be reintegrated back into mainstream school?

Roles
What is your role within the rehabilitation process?
How long do you tend to be involved for?
What is the nature of the work that you do?
Do you tend to administer cognitive assessments?
What psychological theories or models do you apply to practice?
Which theories and models do you find to be the most useful?
How do you work with parents and families to support their needs too?
How do you work with schools?
Which other agencies do you work with and what does this look like?

Rehabilitation
How long do children tend to be at the hospital for?
How do staff here help to reintegrate children back to school?
How do you communicate information around specific areas of need with teaching staff and parents?
Are there any formal processes in place for this?
What other professionals do you work with in schools and outside agencies?
Do you tend to collaborate with EPs in the local authority?

Do you feel that visiting EPs in schools have a unique contribution to make to the reintegration process? If so what is their unique contribution?
How do you liaise with the LA about school placements?

Other

Is there anything else that you would like to add to the interview?
I will transcribe the main themes from this interview and email them to you just to ensure that I have understood and represented your answers accurately.

Thank you for your time, finish.

Interview schedule 2:
Heather Ball
30/11/2010
Specialist rehabilition centre

Participants role: Clinical Psychologist

1. Introductions
2. Purpose of the interview
3. Consent and ethical considerations

4. Interview structure

Processes
How do you become involved with children and young people at Xxx?
What are the main needs of children that you are working with?
How do you think your work might be different to that of a clinical psychologist working in a hospital or clinic for children with ABI?

Roles
What is your role within the rehabilitation process?
How long do you tend to be involved for?
What is the nature of the work that you do?
How do you work with parents and families?
Which psychological models and theories do you apply to your work?
Are there particular aspects of psychology that you find most applicable to your role?
How does the work that you do here at Xxx differ from that of the EPs here?
There seem to be lots of individuals working together around the needs of children here, how do you work collaboratively with other professionals here?
What processes are involved to facilitate goof multi agency working and practice?

Rehabilitation

How long do you tend to work with children for and how often?
How do staff here help to reintegrate children back to school?
Do children tend to go back to mainstream school?
How do you communicate information around specific areas of need with teaching staff and parents?
Are there any formal processes in place for this?
What other professionals do you work with in schools and outside agencies?

The role of the EP

How do you perceive the role of the EPs that work here at Xxx?
Is there something unique that EPs here contribute to working with children who have ABI? If so what is their unique contribution?
Is the reintegration process a collaborative effort or does one professionals take a lead?
Do you tend to collaborate with EPs in the local authority?

Do you feel that visiting EPs in schools have a unique contribution to make to the reintegration process?

Other

Is there anything else that you would like to add to the interview?
I will transcribe the main themes from this interview and email them to you just to ensure that I have understood and represented your answers accurately.

Thank you for your time, finish.

Interview schedule 3:

Heather Ball
30/11/2010
Interview schedule
Specialist rehabilition centre

Participants role: Educational Psychologists

1. Introductions
2. Purpose of the interview
3. Consent and ethical considerations

4. Interview structure

Processes
How are children and young people referred to Xxx?
What is the process of referral? And who decides?
Is this paid for privately by parents or the NHS?
Do children tend to have an acquired brain injury caused by an external impact?
What are the main needs of children referred to Xxx?
How is this referral process different to children that go from hospital directly back to school?

Roles
What is your role within the rehabilitation process?
How long do you tend to be involved for?
What is the nature of the work that you do?
Do you tend to administer cognitive assessments?
What psychological theories or models do you apply to practice?
Which theories and models do you find to be the most useful?
How do you work with parents and families to support their needs too?
How do you work with schools?
There seem to be lots of individuals working together around the needs of children here, how do you work collaboratively with other professionals here?
What processes are involved to facilitate goof multi agency working and practice?

Rehabilitation
How long do children tend to be at Xxx for?
How do staff here help to reintegrate children back to school?
Do children tend to go back to mainstream school?
How do you communicate information around specific areas of need with teaching staff and parents?
Are there any formal processes in place for this?
What other professionals do you work with in schools and outside agencies?
Do you tend to collaborate with EPs in the local authority?
Do you feel that visiting EPs in schools have a unique contribution to make to the reintegration process?

Other

Is there anything else that you would like to add to the interview?
I will transcribe the main themes from this interview and email them to you just to ensure that I have understood and represented your answers accurately.

Thank you for your time, finish.

Interview schedule 4:

Heather Ball
30/11/2010
Specialist rehabilitation centre

Participants role: Head of medical PRU

1. Introductions
2. Purpose of the interview
3. Consent and ethical considerations

4. Interview structure

Processes

Do all children who attend Xxx access the PRU?
What does the PRU involve?
How are children and young people referred to the PRU?
What is the process of referral? And who decides?
What are the main needs of children referred to the PRU?
How is this referral process different to children that go from hospital directly back to school?

Roles
What is your role within the rehabilitation process?
How long do you tend to be involved for?
What is the nature of the work that you do?
How do you work with parents and families to support their needs too?
How do you work with schools?
There seem to be lots of individuals working together around the needs of children here, how do you work collaboratively with other professionals here?
What processes are involved to facilitate goof multi agency working and practice?

Rehabilitation

How long do children tend to be at Xxx for?
How do staff here help to reintegrate children back to school?
Do children tend to go back to mainstream school?
How do you communicate information around specific areas of need with teaching staff and parents?
Are there any formal processes in place for this?
What other professionals do you work with in schools and outside agencies?
Do you tend to collaborate with EPs in the local authority?

The role of the EP

How do you perceive the role of the EPs that work here at Xxx?
Is there something unique that EPs here co

ntribute to working with children who have ABI? If so what is their unique contribution?
Is the reintegration process a collaborative effort or does one professionals take a lead?
Do you tend to collaborate with EPs in the local authority?
Do you feel that visiting EPs in schools have a unique contribution to make to the reintegration process?

Other

Is there anything else that you would like to add to the interview?
I will transcribe the main themes from this interview and email them to you just to ensure that I have understood and represented your answers accurately.

Thank you for your time, finish.

Interview schedule 5:

Heather Ball
30/11/2010
Interview schedule
Specialist rehabilition centre

Participants role: Occupational Therapist

1. Introductions
2. Purpose of the interview
3. Consent and ethical considerations

4. Interview structure

Processes

How do you become involved with children and young people at Xxx?
What are the main needs of children that you are working with?
How do you think your work might be different to that of an OT working in a hospital for children with ABI?

Roles
What is your role within the rehabilitation process?
How long do you tend to be involved for?
What is the nature of the work that you do?
How do you work with parents and families?
There seem to be lots of individuals working together around the needs of children here, how do you work collaboratively with other professionals here?
What processes are involved to facilitate goof multi agency working and practice?

Rehabilitation

How long do you tend to work with children for and how often?
How do staff here help to reintegrate children back to school?
Do children tend to go back to mainstream school?
How do you communicate information around specific areas of need with teaching staff and parents?
Are there any formal processes in place for this?
What other professionals do you work with in schools and outside agencies?

The role of the EP

How do you perceive the role of the EPs that work here at Xxx?
Is there something unique that Eps here contribute to working with children who have ABI? If so what is their unique contribution?
Is the reintegration process a collaborative effort or does one professionals take a lead?
Do you tend to collaborate with EPs in the local authority?

Do you feel that visiting EPs in schools have a unique contribution to make to the reintegration process?

Other

Is there anything else that you would like to add to the interview?
I will transcribe the main themes from this interview and email them to you just to ensure that I have understood and represented your answers accurately.

Thank you for your time, finish.

Interview schedule 6:

Heather Ball
30/11/2010
Specialist rehabilitation centre

Participant's role: Speech and Language therapist

1. Introductions
2. Purpose of the interview
3. Consent and ethical considerations

4. Interview structure

Processes

How do you become involved with children and young people at Xxx?
What are the main needs of children that you are working with?
How do you think your work might be different to that of an S & L therapist working in a hospital or school for children with ABI?

Roles
What is your role within the rehabilitation process?
How long do you tend to be involved for?
What is the nature of the work that you do?
How do you work with parents and families?
There seem to be lots of individuals working together around the needs of children here, how do you work collaboratively with other professionals here?
What processes are involved to facilitate goof multi agency working and practice?

Rehabilitation

How long do you tend to work with children for and how often?
How do staff here help to reintegrate children back to school?
Do children tend to go back to mainstream school?
How do you communicate information around specific areas of need with teaching staff and parents?
Are there any formal processes in place for this?
What other professionals do you work with in schools and outside agencies?

The role of the EP

How do you perceive the role of the EPs that work here at Xxx?
Is there something unique that Eps here contribute to working with children who have ABI? If so what is their unique contribution?
Is the reintegration process a collaborative effort or does one professionals take a lead?
Do you tend to collaborate with EPs in the local authority?

Do you feel that visiting EPs in schools have a unique contribution to make to the reintegration process?

Other

Is there anything else that you would like to add to the interview?
I will transcribe the main themes from this interview and email them to you just to ensure that I have understood and represented your answers accurately.

Thank you for your time, finish.

Appendix 2- An example of the consent forms used for all participants

1st November 2010

Dear Colleague,

I am currently in my final year of a doctorate in Educational and Child Psychology at the University of Birmingham. As part of the University's requirements we are asked to complete four professional practice reports (PPRs). PPRs comprise exemplar reports of selected areas of the supervised professional practice undertaken during the second and third years of the postgraduate professional training programme.

I am particularly interested in the role of the Educational Psychologist (EP) in working with children who have an acquired brain injury, and in particular how EPs might best support children and teachers through rehabilitation and back into full time education. I would like to conduct several interviews with those professionals who work closely with children who have recently acquired a brain injury to begin to understand the processes of reintegration back into education and how schools may be supported with this group of children and young people. The types of questions I will ask will therefore be around your role and your perception of the role of the EP in supporting reintegration for children with an acquired brain injury.

The interviews should last around 30-45 minutes and may be recorded using a Dictaphone just to ensure that I do not miss any information. Once the information has been transferred to a written form the voice recordings will be deleted. For the write up of this piece of research, your views will remain anonymous, that is your names will not be published although I may refer to individual roles within the write up of the research.

If you are happy to give consent for me to use your views as part of my doctoral research, could you please read, tick and sign the information on the back of this letter. In the mean time, if you have any questions or queries, please do not hesitate to contact me.

Yours sincerely

Heather Ball
Trainee Educational Psychologist
University of Birmingham
Edgbaston
Birmingham
B15 2TT

Mobile telephone number: xxx
Email: xxxx

Please indicate that you understand the following information by putting a tick in the appropriate box:

Research criteria **(Based on guidelines for minimum standards of ethical approval in psychological research produced by the British Psychological Society).**	**I understand this information** (√)	**I <u>do not</u> understand this information** (√)
The interview may be recorded on a Dictaphone just to ensure that I do not miss anything. Once your views have been written down, the voice recording will be deleted.		
Your views will remain anonymous, that is your name will not be mentioned in the report although your job title may be referred to.		
You have the right to withdraw from the research at anytime without giving a reason.		
If we have already collected information from you and you choose to withdraw from the research, you also have the right to withdraw all the information you have given us to date.		
Data from the research will be kept in a secure location within Birmingham's Educational Psychology Service		
Anonymous findings from the study will be shared with academic staff and students at Birmingham University, individuals within the local authority and other members of the research community.		
Data will be gathered by a Trainee Educational Psychologist within Birmingham's Educational Psychology Service.		

I have read and understood the above information and give my consent for Heather Ball to use the data from my interview as part of her doctoral research.

Signed : …….
Job title: …….
Date: ……

Please return to xxx, by the 15th November 2010.

Appendix 3- The process of thematic analysis (Braun and Clarke, 2006)

Table 1: Phases of thematic analysis

Phase	Description of the process
1. Familiarising yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviving themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix 4- An example of an interview transcript from the children's hospital interview

Interview with local children's hospital
Roles- Clinical Psychologist/Paediatric Neuropsychologist

How are children referred to you at the hospital?

We have a neuro rehab team based at the hospital so that's headed up by a community pediatrician who is based part time at the hospital and half of the time at the CDC. Then there is myself (CP), the OT and physio and there is a teacher as well, basically anyone that comes in that has had a RTA or an ABI tends to go to that team. Also we have more general cases, so for example children who may have had a cardiac operation and needed CPR for half an hour or something and you think there is going to be some hypoxic injury will come to that team as well. So there are lots of consultants that will refer to that team and they have a meeting every week which I also go to.

So for children that are going to be in for a while, do they stay in the actual hospital directly after the Injury?

Yes, we also get some that come in for 24/48 hours, the head consultant will try to find out about them and follow them up but the rest of us won't always get involved. So there is potentially a large group of children with mild head injuries that we don't really get to see and we don't really know what happens. The severity of injury is determined by the GCS and the level of injury they have. Most cases that come to us would have spent some time in ICU and will therefore have significant injuries at that point and will come onto the ward which is generally the point where I would start to see them.

Does the nature of injuries tend to be external or internal?

Of the 12 that I have seen recently 7 have been RTA, 3 who have spontaneous bleeds and a couple with infections or an abscess on the brain.

Does the hospital have a breakdown of that information?

No it's one of the difficulties with head injuries , it's really difficult to get accurate information. Each hospital has their own database but it doesn't give you an indication of the severity really. The statistics are that you have a 1/15 chance of having a head injury by the time you are 15 that requires some treatment and head injuries account for around 1/3 of all admissions in terms of accidents and account for a substantial number of deaths in children as well. So there is that data around. There are also national estimates based on the Office and population surveys etc.

That's quite a high number really, as an EP you don't seem to come across children with significant brain injuries very often but I would expect that this population is larger than we think?

we are dealing with the severe end but some children have very mild injuries and go back to school and as such, may be viewed as the silent population. Generally speaking, schools are not alerted and yet the child may have difficulties concentrating, have some post traumatic symptoms, there are a whole range of difficulties that children with minor injury might have but we would not necessarily be alerting the LA about them. Whereas if you have a child with physical injuries as well as a head injury, schools would notice them more. There is a whole literature now around children with mild head injuries, David Johnson up in Scotland did some research with an EP(?) and found that there was a phenomenal number of children who were in schools with brain injuries , of and a significant number of teachers were no aware of this. The teachers did not know.

You get the children going out looking fine but there difficulties become more apparent when they move to high school and you change the demands because they are having to use more of the frontal processes and then people might begin to think that something is not quite right here bit it takes someone to look back and make the connection which sometimes they don't.

What are the main needs of children that are referred here, what is your role within meeting those needs?

Often with a child, it's nothing at first because they are not at a stage where they can access the assessments so we work with families and parents. One of the big things on the ward is helping staff to deal with challenging behaviour, so that side of things is where we get involved and also supporting therapists such as the physio for example they might be struggling with engaging or something within therapy and ask us to come along and have a look.

What would the therapy look like from a CP perspective?

The earlier process is more advice so even though the OTs and physios work in neuro, they work on a rotation basis so wouldn't necessarily have the experience with children so we might get someone who has a child with a head injury who is quite early on in the recovery and therefore have a poor level of language and staff might be giving them complex multiple verbal instructions and actually you need to break it down to concrete instructions with visual prompts. So some of it is education in helping them to understand what the injury mean for that child and how they need to change what they are doing to get the best out of them.

And does your role extend beyond discharge?

We tend to do a neurospsych assessment 3-6 months after discharge but unfortunately it doesn't go much further than that. So I would do some baseline assessments and sessions around adjustment and behaviour in the home but then it doesn't go much further than that.

So when a child is ready to engage would you do an initial assessment at the beginning and the end?

It's something that has to be done at least 3-6 months post injury but if you're not going to gain anything meaningful from it you might do it further down the line.

What's involved in a neuropsychological assessment?

I think the big thing is that your using your assessments in different ways so your not just trying to get the number out of it, you're thinking what is the injury that this person has sustained, what would I predict their injuries might mean and then using your WISCs etc to get some baseline and looking at the results in more detail, attention processes, memory, executive function are often the ones we see a big change in. so it's trying to understand those things really and then giving recommendations about how we might support the family and also schools in that context. The main components of an assessment would be a clinical interview and administration of a number of neuropsychological tests. Performance would be compared to data available from before the accident.

Does a report go to school or is there someone that fills that gap between the report and the neuropsychology kind of jargon terminology?

We have a discharge planning meeting quite early on really to which we try to get someone from school to come along to as well as maybe the community nurse or social services , often it's the senco that comes along to those meetings they get involved quite earlier on in terms of us predicting what might happen which is often the difficulty as we don't know how the child might recover, so you know one meeting they might come along and not be able to walk and the next they could be using a standing frame but schools can do some of that bridging. We also have a school in the hospital which does a lot of liaison with the school to help them find out what has happened previously and which educational placement might be appropriate.

Is that the SENCO from the school that the child has come from?

Yes.

How do the hospital schools work? Do children need a statement to go here?

We have two hospital schools, there is one that any patient can access and then there is another school for children who have more difficulties outside of the hospital and children need a statement to go there.

It seems that EPs pick up these cases further down the line when children do need statements. I think what tends to happen in the community is that a child will come here, there will be an early liaison with clinical psychology and the community pediatrician who will relate to a neuropsychologist in the community which is very rare who might then take the referral to CAMHs and would not necessarily contact the school until further down the line so a child may have returned to school and there will be a meeting with the paediatrician, teacher etc so a plan for recovery or a staged recovery will be put in place but it could be several months if not a year before a statement comes in. In a way, we can pre-empt what the problems might be, schools are really reluctant to put forward for a statement until they have reached the code of practice.

Do parents tend to request SA or is it mainly schools?

I think a bit of both, I think parents notice a change in their children and because schools can be very nurturing there might not be any pressure on a child. It's not really until transition into secondary school or more demands are begin put on children who may be cognitively compromised that teachers begin to see that actually this child is not the same as he or she used to be.

What's the difference between children who attend the hospital compared a specialist rehabilitation unit?

This is an acute unit, so the idea is that once a child is medically stable they should be discharged, however there aren't many services to look after children with ABI and the level of experience for people to do that. So although the rehab team can provide quite a lot of input in terms of OT, physio etc, technically once they are stable people are wanting them out. But we know that there is still an ongoing need for rehab but we can't always find that in the community. That's where you might get private rehabilitation services like xxx but that's very expensive and it's very difficult to get them in. We have had two cases in the same authority that we have tried to get in, one we managed to but after he had been at home for 5 weeks and taken a significant step back.

There has been talk for years and years of having a half way house for children who are not quite ready to go back to school and some of them do need intensive rehabilitation and may have behavioural difficulties that can't be managed at home. This school seems like quite a neat idea in a way because most of the rehab for children with ABI actually happens in special schools where they end up having their rehab informally through a speech and language therapist in the school etc. From my experience, the ep has a very little role in supporting this process in special schools i.e, designing targets and supporting teachers through this process. For years when I was working in the community, it was me who would go in and support schools but actually the EP is in situ and is in a great position to be a able to train teachers about behaviour management strategies, cognitive strategies etc. the genuine feeling was that eps didn't feel that they have the training to do this and I think that would be true nationally. Our experience in this area is that EP have very little input in this area. I think it would be a really helpful role for the EP to translate reports for schools, I think as much as we try to write reports that are not too technical they are often aimed at professionals rather than the family.

In terms of the psychological models or theories that you use, are there any that you feel guide your work or that you find most useful?

I think for me, it depends on the family. Sometimes when working with the family you get into more of a therapeutic role with them and so it's a matter of personal choice. For me , I would be looking at a narrative perspective and the stories that the family has and the family system, thinking about how the child might be? How do you think you might cope with a child who might not be the same? Other psychologists might look at a more CBT type approach.

I think all of those things, we often end up working very individually with each member of the family. The difficulty with that is that each member might be at a different stage of bereavement. When there is a family system, having a child with a brain injury is often described as a family affair as it affects the whole family. We are often drawn into behaviour management which is not directly therapeutic but we often get asked about behaviour such as a child kicking their siblings so we often give behaviour management advice but I think in terms of individual acceptance and post traumatic effects it really does come down to therapeutic work.

How much time would you say you spend working with families and individuals?

I would say 60% is working with parents, 20% with schools and 20% with the child. A lot of it is less therapeutic work with the child at the initial assessment and more about working with the families and helping parents when working in the community. I would say it's the same when working with children as in patients, definitely initially we spend the whole time working with parents.

How do you work with schools, what does that kind of work look like?

Schools tend to come to the discharge meetings and depending on where the child is at that point will depend on how much we get involved with the schools. Often I get involved as part of my assessments, I have got someone who I assessed a couple of weeks ago and am working with the school to try to bring them up to date about what the assessment says and raise some concerns because she had her injury in June and has had some tuition at home but has not gone back to school, she is due to go back in Jan but I don't think she will be ready so I starting liaising with them to get them thinking about what we might do and where she will go so that tends to be the role that I have with schools. Within the assessments that I do, there are always recommendations at the end that help schools to think about processing, attention and concentration etc.

In my previous role working in the community, we would have a report from here and then do an assessment a few months later because you are in a steep learning curve for the first year of recovery and then things start to plateau. The report is for parents and teachers to help them understand the child's difficulties. The liaison would be more about giving advice to teachers about what to do in the classroom but I don't know if that's our domain and this is where a good relationship between the EP and CP is important. Our role is working with families and children in the home although we recognize that the two contexts overlap so I was always very conscious not to tred on the EPs toes so that caused a bit of an internal problem for me. In a way the EP could be informed right from discharge, I think that would really help a lot in being able to orchestrate what the support the child needs. I think that does happen sometimes but because of limit resources we have here can't always be available to schools.

In terms of the role of the EP in the authority, one of the contributions you have mentioned is to be informed of a child when they are discharged, what other contributions do you think EPs could make to children with ABI?

I think they could be a really useful point of contact to recognize that a child is not functioning as well as they used to, the other mistake that schools make is that just

because a child is functioning at average range doesn't mean that a child is not cognitively compromised. They may have been functioning at a high average level prior to the accident and now have difficulties with other functions such as attention and contribution so you could potentially have a child going back to school and it then takes a year or so manage to see that there are difficulties and alert outside teams. My dream I suppose would be that the EP has contacts with the LA who has a key person responsible for keeping a register of children in the area who have had an ABI and alert the school that this child is going to be returning.

Do you feel that there is a need for EPs to become more specialized in this area of they are to be the liaison point do they need to be more informed on the needs of these children?

I think one of the problems is that relatively speaking compared to other injuries is that the numbers are low so in terms of the EP resource that might take a lot of time to become trained in the area and might not justify the investment. It seems to me that it would make more sense to have someone dedicated that was maybe a child neuropsychologist or at least had some expertise and awareness of where to refer children onto but would cover schools to provide assessments and advice on the behaviour support for these children. People may have an aspect of their job that could be dedicated to that population. It would make sense to have one or two specialist EPs that could go into schools.

I don't think that detracts from the idea that EPs need training in this area just to be alerted to the signs and needs of these children but I do still think there is a need for a neuropsychologist.

There might be some difficulties in deciding who fulfils that role because I have referred a child to CAMHs where a neuropsychologist might be able to follow them up but children with an ABI don't always fit the criteria for a CAMHs referral. You do go into a mist in that nobody will quite pick them up and they maybe get lost.
I think some schools are really on the ball, I worked with a school where unfortunately there were several head injuries within each year because the school was located on a main road but school made it their business to find out as much about brain injury as they could. I think it's that kind of awareness that schools needs.

And do you offer any training to schools?

We don't, I have been approached previously in my own job but we are very much hospital based here. I think as we have this interview it seems sad to think that I was having these same discussions 10 years ago and things just have not moved on and I think the reason that things haven't moved on is because of funding. Whilst the number of children with ABI is relatively small the impact is massive. The government have been really reluctant to put money in the area apart from those that have had strokes but then you have the numbers to justify that. Whereas children with ABI, its charity organizations that are generally being the fighting force and trying to attract funding for this population of children. PCTs these days need to try and justify where there money is going , are going to be looking at how much operations can we do in a year rather than we have to spend 50,000 on this child and going to a brain injury unit is not a priority.

The development of paediatric neuropsychology services started off with a few interested people and now most of the knowledge around ABI comes from the theoretical field of neuropsychology, I think EPs might have fallen a little bit behind this, not through a lack of interest but a lack of neuropsychology being translated through to education.

What are your frustrations in your role?

Every area is different so when your trying to find out what's available and what children can access its varies massively. So it might be that I have done this assessment, I know where their difficulties lie but who is going to pass this on. It's not necessarily just local children that we work with and even locally the provision varies so much. I think that's the real frustration, we need something in-between. It's not always appropriate for children to stay in acute care for that amount of time because that does create issues for the relationships that they form with staff and how appropriate that is and they are not at a level where they will need that type of care but they will need intensive rehab that will help them to continue to progress and we do not have that. So they are left in limbo and you know that these are the children that will be having behavioural difficulties at school, or sent to prison or who know what and actually the long term prognosis for them is really poor but if we can get in now and have a structured approach we can create massive changes for them but as X said they are actually quite a small group but if you don't do anything the impact is massive.

I don't think Special schools realise how much money they save the health service in terms of rehab because if you think about adult health services, they don't have school so they have to have a service in the community. Children are looked after by their parents so they are providing some rehab and the school actually does the rest. There was some talk about joint funding between social care and health because what tends to happen is that children will go back and forth between health issues and social issues and no one really grasps the response. Some community resources do have that long term strategy for funding but that's not universal. I think that would be a good thing for services to come together and have a pocket of money to fund this group if children and help them deal with what is effectively a life long condition.

Is there anything else you would like to add?

I think that it would be useful for Educational Psychologists and other staff to know when and where to refer to CAMHs for those with emotional and/or behavioural concerns, because although some of them are organically driven , CAHMs may still have a role? Ct certainly, training for EPs and teaching staff about the emotional and behavioural aspects of an acquired brain injury would be really useful. And EPs need to meet up with colleagues from CAMHs to share ideas, we used to have three monthly meetings to share information about head injuries and it was really useful to do that.

One of the things that EPs need to be aware of is that there is often a litigation case going on so other professionals might also get involved in assessments, is it likely that another expert will be doing their own assessments. There are problems with this, one

of which is the time between assessments e.g., the WISC if two professionals have carried out the same assessments ether will be massive practice effects. I have had a case where a private expert had been in the week before to do an assessment and then looking through the notes, an EP had also been in two months before and completed the same assessment and so you have these really skewed WISC results that mean nothing so EPs just need to be mindful of this.

In terms of these overlapping assessments, what do you think an EP could do that is different, what unique contribution could they make to an assessment for a child who has experienced an ABI?

EPs tend to focus in my experience on the BAS and achievement skills but they don't look at memory, processing speed or attention so there is a little bit of a mismatch there and a neuropsychologist would be interpreting those results in terms of how the brain works and the injury to the brain whereas an EP would just be interpreting them in terms of this is how the child presents. Some children will come out as average but perhaps had a much higher I.Q Recognising that it it's the rate that the child learns r as well as overall achievement is important. Also the ability to monitor over time which an EP could do.

Appendix 5- An example of some of the key themes generated from the data

Thematic analysis- Phase 2- coding data

Interview	Data extract	Coded for
Children's hospital	There is potentially a large group of children with mild head injuries that we don't really get to see and we don't really know what happens.	Mild head injuries – tend to be missed
	Most cases that come to us would have spent some time in ICU and will therefore have significant injuries at that point and will come onto the ward which is generally the point where I would start to see them.	Extent of injuries- acute care
	The statistics are that you have a 1/15 chance of having a head injury by the time you are 15 that requires some treatment and head injuries account for around 1/3 of all admissions in terms of accidents and account for a substantial number of deaths in children as well	Statistics of children affected
	Because children with an ABI are a silent population, we are dealing with the severe end but some children have very mild injuries and go back to school and school are not alerted and yet the child may have difficulties	Lack of communication to schools- impact of mild head injuries
	there are a whole range of difficulties that children with minor injury might have but we would not necessarily be alerting the LA about them	Impact of mild head injuries
	You get the children going out looking fine but there difficulties become more apparent when they move to high school and you change the demands because they are having to use more of the frontal processes and then people might begin to think that something is not quite right here bit it takes someone to look back and make the connection which sometimes they don't.	Changing demands of school make head injury more noticeable but who identifies cause?
	we work with families and parents	Working with families
	One of the big things on the ward is helping staff to deal with challenging behaviour	Dealing with challenging behaviour in consultation role
	So some of it is education in helping them to understand what the injury mean for that child and how they need to change what they are doing to get the best out of them.	Educating others

	We tend to do a neurospsych assessment 3-6 months after discharge but unfortunately it doesn't go much further than that	Neuropsychological assessments
	We have a discharge planning meeting quite early on really to which we try to get someone from school to come along to as well as maybe the community nurse or social services , often it's the senco that comes along to those meetings	Discharge meetings- importance of attendance Cascading information
	We also have a school in the hospital which does a lot of liaison with the school to help them find out what has happened previously and which educational placement might be appropriate.	Use of hospital schools- liaise with mainstream
	so a child may have returned to school and there will be a meeting with the pediatrician, teacher etc so a plan for recovery or a staged recovery will be put in place but it could be several months if not a year before a statement comes in	Use of a statement- time delays
	It's not really until transition into secondary school or more demands are begin put on children who may be cognitively compromised that teachers begin to see that actually this child is not the same as he or she used to be.	Changing demands as child gets older, the impact of head I jury becomes more noticeable.
	however there aren't services to look after children with ABI and the level of experience for people to do that.	Services in the community after discharge
	But we know that there is still an ongoing need for rehab but we can't always find that in the community	Lack of services in the community
	There has been talk for years and years of having a half way house for children who are not quite ready to go back to school and some of them do need intensive rehabilitation and may have behavioural difficulties that can't be managed at home	Use of a half way house to support the needs of children with a ANi in the community
	From my experience, the EP has a very little role in supporting this process in special schools i.e, designing targets and supporting teachers through this process.	EP role- could support special schools more with the rehabilitation of children with ABI
	actually the EP is in situ and a great position to be a able to train teachers about behavior management strategies, cognitive strategies etc. the genuine feeling was that eps didn't feel that they have the training to	EP role- ideal location to train teachers EP- lack of training in this area, lack of input EP role- translate reports for

	do this and I think that would be true nationally. Our experience in this area is that EP have very little input in this area. I think it would be a really helpful role for the EP to translate reports for schools, I think as much as we try to write reports that are not too technical they are often aimed at professionals rather than the family.	schools
	we often end up working very individually with each member of the family	Working with families
	having a child with a brain injury is often described as a family affair as it affects the whole family	Working with families
	For me , I would be looking at a narrative perspective and the stories that the family has	Narrative psychology
	We are often drawn into behaviour management	Behaviour management
	Schools tend to come to the discharge meetings and depending on where the child is at that point will depend on how much we get involved with the schools.	Role of schools- discharge meeting
	Within the assessments that I do, there are always recommendations at the end that help schools to think about processing, attention and concentration etc	Recommendations in reports to schools
	In a way the EP could be informed right from discharge, I think that would really help a lot in being able to orchestrate what the child support the child needs. I think that does happen sometimes but because of limit resources we have here can't always be available to schools.	Role of EP- To be informed at discharge Role of EP- Orchestrate support
	I think they could be a really useful point of contact to recognize that a child is not functioning as well as they used to	Role of EP- Monitor progress in school
	My dream I suppose would be that the EP has contacts with the LA who has a key person responsible for keeping a register of children in the area who have had an ABI and alert the school that this child is going to be returning.	Role of LA- To record children who have head injuries Communication between agencies
	It seems to me that it would make more sense to have someone dedicated that was maybe a child neuropsychologist or at least	Role of EP- training in neuropsychology

	had some expertise and awareness of where to refer children onto but would cover schools with certain parts of the behaviour support for these children. People may have an aspect of their job that could be dedicated to that population. It would make sense to have one or two specialist EPs that could go into schools.	Role of EP- use of specialist within an EPS
	I don't think that detracts from the idea that EPs need training in this area just to be alerted to the signs and needs of these children but I do still think there is a need for a neuropsychologist.	EP training
	It's not always appropriate for children to stay in acute care for that amount of time because that does create issues for the relationships that they form with staff and how appropriate that is and they are not at a level where they will need that type of care but they will need intensive rehab that will help them to continue to progress and we do not have that. So they are left in limbo	Lack of resources for continued rehab
	I think we have focused a lot on the cognitive side but some of the work that also needs to be done is dealing with the emotional side of an ABI	Work with emotional wellbeing
	One of the things that EPs need to be aware of is that there is often a litigation case going on so other professionals might also get involved in assessments, is it likely that another expert will be doing their own assessments. There are problems with this, one of which is the time between assessments e.g., the WISC if two professionals have carried out the same assessments ether will be massive practice effects.	Working with other psychologists Practice effects of assessments
	Some children will come out as average but perhaps had a much larger IQ before and that where the most significant contribution could be, that it's the rate that the child learns rather than overall achievement and monitoring over time which an EP could do.	Role of EP- monitoring progress of children with an ABI
Interview with	One of the key things is working with	Working with families

EPs from national specialist rehabilitation unit	parents to explain that their child may have SEN but that has to be very delicate and needs to be handled with a high degree of sensitivity.	
	Well I have done some neuropsychological assessments, now we have increase the number of psychologists on the team I have been able to focus more of the educational psychology part of our role	Use of assessments
	I have done some cognitive work, psychological assessments (cognitive , emotional, contextual, narrative work)	Use of assessments
	In the real world there are very few paediatric neuropsychologists available and I think it is an area that EPs are well placed to increase their skills and continue developing within the community. There are only very few children who get to participate in formal rehabilitation programmes like ours, most children are discharged from hospital and go straight back to school.	Training for EPs
	Systemic and Developmental psychology plays a huge part of our work because an ABI in a child is so very different to an adult, i.e.,an adult has a fully developed brain, whereas the brains of all the children we are working with continue to develop either typically or atypically is a major issue to us but we need to near in mind the developmental aspect, it's crucial	Application of developmental psychology
	Children are funded by the PCT of their local health author	Funding
	we are all the time aware of that our assessment could be limited by that time when we need to fit in an awful lot of work and its about the transition work as well as the work here.	Time limited rehabilition
	Working with families is crucial so that we can do our job and working closely with the family because they of course are going to be involved in working with the LA around statutory assessment and also we take account of the needs of the family as a whole	Working with families
	An ABI for the child is an ABI for the whole family and it can have a huge impact	Impact on families,

	on the siblings and it can be helpful to liaise with their schools to check that all is well (for siblings as well).	Working with families
	We get in contact very quickly actually with the school that children are on role with, usually with the head teacher or senco . We explain our role and ask to know more about the child It's very helpful to know about the child from their point of view and then we talk about the own resources are with reference to SEN which is variable, we just get a feel of support	Working with schools
	We do engage with the local authority EP which again is a crucial aspect, ideally the EP would come here. There are huge benefits from getting the EP involved from a very early stage. It's important for the EP to take ownership so to speak of what the needs of the child are because of the enduring problems post-injury.	Working with the LA EP
	EP on the ball especially if it's an ambulant child who looks and sounds fine, it helps to alert the local EP to the range of cognitive difficulties and potential behavioural implications	Role of EP- to monitor progress
	I have come across one authority where one EP had done a previous assessment and then also took on this one and was therefore beginning to develop a specialism within their authority. The amount of new information required can be a lot to take in.	Need for a specialist EP in the authority
	There are key people, the LA, the EP and the parents and that we generally do after discussing with the parent about SA, we then encourage them to inform their LA that their child is probably going to have some SEN	Statutory assessments
	I think our role can be about being an advocate for the child and family because we are not employed by the authority then we really can be true advocates without having to think about policies that we have to abide by	Advocate for parents and families
	That is ideal because that is when we can put all the transition work in place and the team here have build up some good solid experience of how to do that, training staff in schools, a child's particular needs, how	Having a named school, building up links for reintegration

	they have worked here and that dialogue doesn't always happen before a child goes back to school where a SA is still in process and a school has not been named.	
	But in a special school you might get all the therapists on site and the staff would have some training and level of knowledge in special needs whereas in mainstream you wouldn't always get that	Special school – rehabilitation in one place
	It is useful to somehow get across the idea that children with ABI are very individual so when you have a school, that say that they do not need training because they may have had a child with an ABI 5 years ago. It is useful to know that the school have had some experience but it is also useful to impress on staff that every child with ABI can be so different because it can depend on so many factors; the age of the child, the nature of injury, which part of the brain was affected, all sorts of factors play a part.	Individual needs of a child with ABI, schools need training about their specific needs
	So we offer two levels of training to schools, the first is on the concept of injury to the developing brain and the second is the impact of the injury for that particular child, what approaches could help to meet the needs of that child. We offer any support for differentiating the curriculum or any other information that might be helpful. We usually try to identify the Head or SENCO to talk through the support that needs to be available	Two levels of training; general specific
	It does need to be a wide audience and one of the key difficulties is that when children move class or move schools nobody flags up that the child has had an ABI and it can happen in some of the best schools	Cascading information, Monitoring children
	A child that we had here with very severe ABI and went back to mainstream school who were very supportive. A new teacher started in September after the child had already gone back and the mother called me in great distress to say that the child had been given a detention because she had forgotten to bring her homework back to school . Now this is a child who looks fine but have severe memory impairment bur the teacher looked at her and saw a physically able teenager and therefore gave	An example of how information is not always communication to a wider audience

	her a detention which made her extremely distressed.	
	we are not currently following up children long term	Lack of long term follow up from specialist services
	What we have to impress on the EP is the enduring and chronic nature of ABI, so the child is not likely to get back to the way they were before the injury and it's the EP who is really well placed to follow the child up from class to class, school to school and for that EP to bring in other people who may be able to support if need be, but yes the LA EP has a crucial role.	Role of EP- well placed to follow up and monitor child within school
	I think there is a real need for training for EPs to understand ABI and the nature of the educational implications which is something that EPs don't have a depth of knowledge of but would definitely benefit from. And we are talking about the moderate to severe end but there are a number of other children going from other places with milder injuries.	Training for EPs
	It is such a rich area to tap and so important. If there was an EP in each area that had this specialism, that could work very well.	Need for a specialist role within EPS's
	One of the likely areas is awareness raising because if staff have an understanding of an ABI then they are going to make accommodations for things. It is an understanding tat factors such as fatigue for example and memory and attention will have massive impact for the child,	Role of EP- raising awareness, educating staff
	Local Authority EPs would know about local facilities, and hopefully be in a position to recommend particular on-going support and relevant activities	Role of EPs- knowledge of local provision
	Another thing that we haven't referred to in terms of the role of the LA EP is the ability to translate a clinical report into what might be useful for the school. If we have done some individual work then we try to write a report.	Role of EP- Translate clinical reports.

Thematic analysis- Phase 3 and 4, searching and reviving themes

Interview	Data extract	Coded for	Overall theme	Subtheme
Children's hospital	There is potentially a large group of children with mild head injuries that we don't really get to see and we don't really know what happens.	Mild head injuries – tend to be missed	Population of children with ABI	Mild head injuries
	Most cases that come to us would have spent some time in ICU and will therefore have significant injuries at that point and will come onto the ward which is generally the point where I would start to see them.	Extent of injuries- acute care	Population of children with ABI	
	The statistics are that you have a 1/15 chance of having a head injury by the time you are 15 that requires some treatment and head injuries account for around 1/3 of all admissions in terms of accidents and account for a substantial number of deaths in children as well	Statistics of children affected	Population of children with ABI	
	Because children with an ABI are a silent population, we are dealing with the severe end but some children have very mild injuries and go back to school and school	Lack of communication to schools- impact of mild head injuries	Lack of communication between hospital and schools	Mild head injuries

	are not alerted and yet the child may have difficulties			
	there are a whole range of difficulties that children with minor injury might have but we would not necessarily be alerting the LA about them	Impact of mild head injuries	Lack of communication between hospital and schools	Mild head injuries
	You get the children going out looking fine but their difficulties become more apparent when they move to high school and you change the demands because they are having to use more of the frontal processes and then people might begin to think that something is not quite right here bit it takes someone to look back and make the connection which sometimes they don't.	Changing demands of school make head injury more noticeable but who identifies cause?	Lack of communication between professionals regarding a child's developmental history	
	we work with families and parents	Working with families	Working with families	
	One of the big things on the ward is helping staff to deal with challenging behaviour	Dealing with challenging behaviour in consultation role	Role of Psychologist-consultation	
	So some of it is education in helping them to understand what the injury mean for that child and how they need to change	Educating others	Training for professionals working with children with ABI.	

	what they are doing to get the best out of them.			
	We tend to do a neurospsych assessment 3-6 months after discharge but unfortunately it doesn't go much further than that	Neuropsychological assessments	Lack of follow up support	
	We have a discharge planning meeting quite early on really to which we try to get someone from school to come along to as well as maybe the community nurse or social services , often it's the senco that comes along to those meetings	Discharge meetings- importance of attendance Cascading information	Processes for information exchange	
	We also have a school in the hospital which does a lot of liaison with the school to help them find out what has happened previously and which educational placement might be appropriate.	Use of hospital schools- liaise with mainstream	Processes for information exchange	
	so a child may have returned to school and there will be a meeting with the pediatrician, teacher etc so a plan for recovery or a staged recovery will be put in place but it could be several months if not a year before a	Use of a statement- time delays	Statementing	

	statement comes in			
	It's not really until transition into secondary school or more demands are begin put on children who may be cognitively compromised that teachers begin to see that actually this child is not the same as he or she used to be.	Changing demands as child gets older, the impact of head injury becomes more noticeable.	Importance of monitoring	
	however there aren't services to look after children with ABI and the level of experience for people to do that.	Services in the community after discharge	Lack of follow up support	
	But we know that there is still an ongoing need for rehab but we can't always find that in the community	Lack of services in the community	Lack of follow up support/community services	
	There has been talk for years and years of having a half way house for children who are not quite ready to go back to school and some of them do need intensive rehabilitation and may have behavioural difficulties that can't be managed at home	Use of a half way house to support the needs of children with a ABI in the community	Lack of community services	
	From my experience, the EP has a very little role in supporting this process in special schools i.e, designing targets	EP role- could support special schools more with the rehabilitation of children with ABI	Role of the EP	Supporting special schools in consultation role

	and supporting teachers through this process.			
	Actually the EP is in situ and a great position to be a able to train teachers about behavior management strategies, cognitive strategies etc. the genuine feeling was that eps didn't feel that they have the training to do this and I think that would be true nationally. Our experience in this area is that EP have very little input in this area. I think it would be a really helpful role for the EP to translate reports for schools, I think as much as we try to write reports that are not too technical they are often aimed at professionals rather than the family.	EP role- ideal location to train teachers EP- lack of training in this area, lack of input EP role- translate reports for schools	Role of the EP EP training	Training teachers Translating reports
	we often end up working very individually with each member of the family	Working with families		
	having a child with a brain injury is often described as a family affair as it affects the whole family	Working with families	Working with families	
	For me , I would be looking at a narrative perspective and the stories that the	Narrative psychology	Application of psychology	

	family has			
	We are often drawn into behaviour management	Behaviour management	Role of psychologist	Behaviour management
	Schools tend to come to the discharge meetings and depending on where the child is at that point will depend on how much we get involved with the schools.	Role of schools- discharge meeting	Role of schools	Discharge meetings
	Within the assessments that I do, there are always recommendations at the end that help schools to think about processing, attention and concentration etc	Recommendations in reports to schools	Processes for information exchange	
	In a way the EP could be informed right from discharge, I think that would really help a lot in being able to orchestrate what the child support the child needs. I think that does happen sometimes but because of limit resources we have here can't always be available to schools.	Role of EP- To be informed at discharge Role of EP- Orchestrate support	Role of EP	Facilitate meetings after rehabilitation Informed after discharge
	I think they could be a really useful point of contact to recognize that a child is not functioning as well as they used to	Role of EP- Monitor progress in school	Role of EP	Monitor progress in school
	My dream I	Role of LA- To	Role of LA	Communication

	suppose would be that the EP has contacts with the LA who has a key person responsible for keeping a register of children in the area who have had an ABI and alert the school that this child is going to be returning.	record children who have head injuries Communication between agencies		between agencies
	It seems to me that it would make more sense to have someone dedicated that was maybe a child neuropsychologist or at least had some expertise and awareness of where to refer children onto but would cover schools with certain parts of the behaviour support for these children. People may have an aspect of their job that could be dedicated to that population. It would make sense to have one or two specialist EPs that could go into schools.	Role of EP- training in neuropsychology Role of EP- use of specialist within an EPS	Training for EPs	Specialist role within EPS
	I don't think that detracts from the idea that EPs need training in this area just to be alerted to the signs and needs of these children but I do still think there is a need for a	EP training	Training for EPs	Specialist role

	neuropsychologist.			
	It's not always appropriate for children to stay in acute care for that amount of time because that does create issues for the relationships that they form with staff and how appropriate that is and they are not at a level where they will need that type of care but they will need intensive rehab that will help them to continue to progress and we do not have that. So they are left in limbo	Lack of resources for continued rehab	Lack of follow up support	
	I think we have focused a lot on the cognitive side but some of the work that also needs to be done is dealing with the emotional side of an ABI	Work with emotional wellbeing	Application of psychology	
	One of the things that EPs need to be aware of is that there is often a litigation case going on so other professionals might also get involved in assessments, is it likely that another expert will be doing their own assessments. There are problems with this, one of which is the time between assessments e.g., the WISC if two	Working with other psychologists Practice effects of assessments	Psychological assessments	Practice effects

	professionals have carried out the same assessments ether will be massive practice effects.			
	Some children will come out as average but perhaps had a much larger IQ before and that where the most significant contribution could be, that it's the rate that the child learns rather than overall achievement and monitoring over time which an EP could do.	Role of EP- monitoring progress of children with an ABI	Role of EP	Monitoring progress

Appendix 6- Glossary of medical terms used

Stroke: A stroke, previously known medically as a cerebrovascular accident (CVA), is the rapidly developing loss of brain function(s) due to disturbance in the blood supply to the brain. This can be due to ischemia (lack of blood flow) caused by blockage (thrombosis, arterial embolism), or a hemorrhage (leakage of blood).

Haemorrhage: A cerebral hemorrhage or haemorrhage (or intracerebral hemorrhage, ICH) is a subtype of intracranial hemorrhage that occurs within the brain tissue itself. Intracerebral hemorrhage can be caused by brain trauma, or it can occur spontaneously in hemorrhagic stroke. Non-traumatic intracerebral hemorrhage is a spontaneous bleeding into the brain tissue.

Aneurysm: A localized, blood-filled balloon-like bulge in the wall of a blood vessel. Aneurysms can commonly occur in arteries at the base of the brain (the circle of Willis) and an aortic aneurysm occurs in the main artery carrying blood from the left ventricle of the heart. When the size of an aneurysm increases, there is a significant risk of rupture, resulting in severe hemorrhage, other complications or even death. Aneurysms can be hereditary or caused by disease, both of which cause the wall of the blood vessel to weaken

Meningitis: Meningitis is inflammation of the protective membranes covering the brain and spinal cord, known collectively as the meninges. The inflammation may be caused by infection with viruses, bacteria, or other microorganisms, and less commonly by certain drugs. Meningitis can be life-threatening because of the inflammation's proximity to the brain and spinal cord; therefore the condition is classified as a medical emergency.

Hypoxia/hypoxic: Hypoxia, or hypoxiation, is a pathological condition in which the body as a whole (generalized hypoxia) or a region of the body (tissue hypoxia) is deprived of adequate oxygen supply. Variations in arterial oxygen concentrations can be part of the normal physiology, for example, during strenuous physical exercise. A mismatch between oxygen supply and its demand at the cellular level may result in a hypoxic condition. Hypoxia in which there is complete deprivation of oxygen supply is referred to as anoxia.

Cardiac arrest: Cardiac arrest, (also known as cardiopulmonary arrest or circulatory arrest) is the cessation of normal circulation of the blood due to failure of the heart to contract effectively. Medical personnel can refer to an unexpected cardiac arrest as a sudden cardiac arrest or SCA.A cardiac arrest is different from (but may be caused by) a heart attack, where blood flow to the muscle of the heart is impaired. Arrested blood circulation prevents delivery of oxygen to the body. Lack of oxygen to the brain causes loss of consciousness, which then results in abnormal or absent breathing. Brain injury is likely if cardiac arrest goes untreated for more than five minutes.

Brain tumour: A brain tumor (or brain tumour) is an intracranial solid neoplasm, a tumor (defined as an abnormal growth of cells) within the brain or the central spinal canal.

Brain tumors include all tumors inside the cranium or in the central spinal canal. They are created by an abnormal and uncontrolled cell division, normally either in the brain itself (neurons, glial cells (astrocytes, oligodendrocytes, ependymal cells, myelin-producing Schwann cells), lymphatic tissue, blood vessels), in the cranial nerves, in the brain envelopes (meninges), skull, pituitary and pineal gland, or spread from cancers primarily located in other organs (metastatic tumors).

Encephalitis: Encephalitis is an acute inflammation of the brain. Encephalitis with meningitis is known as meningoencephalitis.

Encephalopathy: Encephalopathy means disorder or disease of the brain. In modern usage, encephalopathy does not refer to a single disease, but rather to a syndrome of global brain dysfunction; this syndrome can be caused by many different illnesses

Brain Abscess: Brain abscess (or cerebral abscess) is an abscess caused by inflammation and collection of infected material, coming from local (ear infection, dental abscess, infection of paranasal sinuses, infection of the mastoid air cells of the temporal bone, epidural abscess) or remote (lung, heart, kidney etc.) infectious sources, within the brain tissue. The infection may also be introduced through a skull fracture following a head trauma or surgical procedures. Brain abscess is usually associated with congenital heart disease in young children. It may occur at any age but is most frequent in the third decade of life.